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ABSTRACT

Designed for use by instructors of training programs for day care and nursery school personnel, this manual provides activities, resources, and ideas to help these caregivers include children with special needs and handicaps in their programs. The activities cover 12 topics in the area of mainstreaming. These topics include the following: measuring and assessing teacher attitudes towards mainstreaming; increasing awareness about children with different handicaps; working with community resources; understanding and helping families with handicapped children; using developmental approaches for assessment and programming of young handicapped children; helping handicapped children develop self-help skills; learning how to deal with handicapped children's communication problems; designing classroom environments for handicapped children; collecting and keeping up-dated information on each child; and designing activities for children with sensory impairments. Each topic is briefly introduced on the first page of the topic section, and is then followed by related activities. Suggestions for additional activities, bibliographies, and other relevant resources close each topic section. An evaluation form for training session participants and feedback form for trainers who use the manual and who are willing to share their comments with the authors are provided in Appendix A. Appendix B contains the handouts described in the "Materials" section of each activity. (Author/MP)

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MAINSTREAMING
CHILDREN WITH HANDICAPS
IN
DAY CARE & PRESCHOOL

A Manual of Training Activities

Spring 1981

Written and edited by
Anne Booth
Patricia Donsbach
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PURPOSE

The purpose of this training manual is to provide activities, resources, and ideas for instructing day care and nursery school personnel so they can include children with handicaps and special needs in their programs.

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BACKGROUND

This manual was developed through PROJECT MAINSTREAM, a grant funded by the Wisconsin Council on Developmental Disabilities under P. L. 95-602. PROJECT MAINSTREAM is based in the Home Economics Division within Madison Area Technical College, Madison, Wisconsin. All activities and ideas in this notebook have been field tested during the 1980-1981 work year. Coursework was offered within a four-county area involving staff from 18 day care or preschool centers. In addition, individual sections of the notebook were developed for presentations at conferences, workshops, and seminars.

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INTRODUCTION

The field of child care is being expanded in many directions. Within recent years the age range has broadened to include infants and toddlers as well as elementary school students who require care during after school hours. Requirements for licensing, training, and inservice have changed. Directors are considering innovative ways to keep centers funded. These are only some of the changes that have been affecting child care.

One of the important changes affecting day care licensing rules involves the addition of a nondiscrimination section in the current licensing standards that includes the child who is handicapped. This means that a day care center or nursery school can no longer turn a child away just because he or she has epilepsy, Down's Syndrome, or other handicapping conditions. To further complicate this issue, most child care training programs prior to 1977 have not included information, coursework, or discussion of children with handicaps. This can leave the day care staff feeling unprepared for this new challenge.

NOW...is the best time to prepare the child care community for MAINSTREAMING children who are handicapped into their programs. More children with handicaps will be entering day care centers and nursery schools for the following reasons:

*Increased Advocacy Efforts. More community programs are including children who are handicapped. Many efforts to improve, expand, and enhance these programs have been undertaken by advocacy groups, parents, and voluntary associations. Legislators have become aware of the importance of providing equality in programming for ALL children.

*Trend Toward Normalization. It has been proven that in order for people who are handicapped to reach their full potential, they need to experience life in as "normal" a way as possible. This includes growing up in the mainstream of society. The most effective way to accomplish this is to allow very young children to participate in home, school and community events with other children whenever possible.

*Increased Parent Awareness. Parents are increasingly becoming aware of their child's handicap while the child is still an infant or toddler. With this awareness comes an acceptance of the fact that their child does have a handicap. As soon as parents are willing to accept a child's problems, they can better deal with their own feelings and emotions and carry on with life in the most normal fashion possible. This includes exploring services in the community that will enhance their child's development.

*Trend Toward Deinstitutionalization. Simply stated this means that children should be raised in their home environment instead of being sent away at a young age and reared in a separate facility for people who have handicaps. Many times physicians have recommended placement of children who might have gained much more from living in their own homes. It used to be routine procedure to send Down's Syndrome children to institutions. Now it is rare to find these children in facilities for handicapped people.

It can be very demanding to care for a severely physically handicapped child at home. Parents who do choose to care for their child at home need assistance and time for themselves. Day care programs can be beneficial for children as well as provide needed respite for parents.

*Increased Demand for Day Care. It is a fact that more mothers are entering the work force each year. Whether the economy is responsible or just the desire for women to have their own careers is not the issue. What is important is that as the number of working women increases, so does the number of children who need child care -- handicapped or nonhandicapped.

*To Supplement Other Programs. Children who have handicaps are often involved in special programs. Both Head Start and public school special education provide programs on a part-day basis. If parents work or attend school themselves, they will most likely need child care for their children after school, on holidays, and during vacations.

We have explored the reasons for continued growth of day care services for the handicapped child and the reasons for providing additional training for staff. The following training activities and suggestions were designed to stimulate awareness, provide general knowledge, and suggest specific techniques that are important for MAINSTREAMING CHILDREN IN DAY CARE AND PRESCHOOL.

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HOW TO USE THE MANUAL

This manual is an introduction to accepting and caring for children with handicaps. It has been designed as an instructor's manual for use in training programs for day care staff, preschool teachers, and others who work with young children. The manual contains activities to be conducted by an instructor with a background in early childhood, special education, or related fields. Trainers are encouraged to enlist local resource people to supplement content areas when they feel it is appropriate.

The contents of the manual originated in an introductory course on mainstreaming and were further refined through training sessions with area day care staff. A final set of activities covering twelve topic areas form the present manual. Each topic is briefly introduced on the first page of the section, followed by a related set of activities. Suggestions for additional activities, references, and further resources close each topic section.

Two Appendices are provided in the manual. Appendix A contains a feedback form for trainers who use the manual and are willing to share their comments with the authors. An evaluation form for training session participants is provided for the trainer's own use. Appendix B contains the handouts described by number and title in the MATERIALS section of an activity. It is suggested that the trainer duplicate copies according to the number of participants involved in the training session or course.

The activities and materials included in the manual can easily be adapted for seminars or workshops. The trainer can select the most relevant activities to meet the needs and interests of the participants. The progression of the sections, however, should be followed. The topics move from a general discussion about mainstreaming and attitude change to more specific disability and program information. This format will allow the participants to begin by addressing the primary goal of opening up programs to all children and then proceed to more specific programming strategies. It is our intent that the manual be used as a springboard to further study of the methods of integrating children with handicaps.

We believe that MAINSTREAMING CHILDREN WITH HANDICAPS INTO DAY CARE AND PRESCHOOL is a useful instructive tool that can be used to increase the chances that all children will truly become part of the mainstream through the integration of early childhood environments.

A. Booth
P. Donsbach
P. Maykut

I. WHY MAINSTREAM?

> Normalization is doing and saying everything we can wherever possible to integrate people who have developmental special needs into everyday community life, to enjoy all that we value for ourselves.
>
> Author Unknown

Mainstreaming children with handicaps in child care settings is an important new concept. Basically, it means giving children with handicaps the opportunity to participate in preschool and day care centers that are available to other children. The primary goal of integration in a child care program is to facilitate the overall positive behavioral, attitudinal, and emotional development of all children involved. On the surface, mainstreaming appears to be a "natural" arrangement, if not a simple one. However, child care workers must carefully explore the reasons to mainstream before enrolling a child with a handicap in their program. Careful exploration of the reasons to mainstream will lead to an understanding of the benefits as well as an awareness of some of the barriers or roadblocks to mainstreaming. Only after careful investigation can a true commitment to mainstreaming actually take place. It is this commitment that is the most important ingredient of a successful integrated program.

ACTIVITY 1 TEACHER ATTITUDE SURVEY

BACKGROUND

An effective method of assessing change in attitude is by using a pre- and post-measure. The following Day Care and Preschool Staff Questionnaire was developed for use at the first and last session of the course. The instrument was designed in the following way: Questions 1-8, general information; questions 9-38 are coded for the following information:

AD - Administrative Concerns
S/I - Segregation vs. Integration
AT - Attitude
T - Teacher Knowledge.

There are no right or wrong answers for this survey since we are measuring the way a person feels about certain issues at a certain time. It would be unfair to say that there are not preferred answers. Hopefully, by the end of the seminar, workshop, or course, the trainer's positive attitude in addition to the class activities, speakers, outside readings, and actual experiences with children who are delayed or handicapped will all have contributed to a commitment with regard to mainstreaming on the part of the participants.

OBJECTIVES

1. To measure attitudes regarding mainstreaming.
2. To make participants aware of their own values and attitudes.
3. To aid in course evaluation.

TIME ALLOWANCE

Approximately 20 minutes

MATERIALS

Copy of survey

PROCEDURES

1. Administer survey at first and last class session.
2. Allow students to note changes after they have completed both pre- and post-surveys.

ACTIVITY 2 WHY MAINSTREAM AND WHAT ARE THE BARRIERS TO MAINSTREAMING?

BACKGROUND

This activity involves participants in structured brainstorming about mainstreaming.

OBJECTIVES

1. Clarify the benefits of mainstreaming for all persons involved.
2. Clarify the roadblocks to mainstreaming.

TIME ALLOWANCE

35-45 minutes

MATERIALS

Chalkboard/chalk or
Overhead/markers or
Flip chart/markers
Handout #2: "Integrating Handicapped Children into Regular Classrooms"

PROCEDURE

1. Ask the question "Why Mainstream?"
2. Prepare a "benefits" column (example below) and have participants brainstorm for each group. A key is provided to illustrate possible responses.

HOW MAINSTREAMING BENEFITS:	KEY
Children who are handicapped	more opportunities for learning, positive models, variety of experiences, positive expectations, natural contingency, more choices, greater range of people to meet, stronger sense of self
Children who are not handicapped	greater range of people, increase understanding
Parents of children who are handicapped	chance to work, go to school, recreate
Parents of children who are not handicapped	increase understanding
Teachers	learn about all children-greater benefits
Centers	better quality
Community	increase its competency, becomes more aware, cost effective
Other	

3. Prepare a "barriers" column column on a chart (example below) and have participants brainstorm for each group. A key is provided to illustrate possible responses.

BARRIERS FOR:	KEY
Children with handicaps	physical accessibility, program accessibility
Children who are not handicapped	fears, lack of understanding
Parents of those who are handicapped	overprotectiveness
Parent of those who are not handicapped	fears, lack of understanding
Teachers	fears, lack of support
Center	lack resources, financing, inherent conditions of day care
Community	fear, system doesn't support mainstreaming
Other	

(Use Handout #2 or other articles for additional information)

4. Conclude the exercise by reviewing all points and explaining that the rest of the training session will be a preparation for facing and moving past the barriers that exist.

ACTIVITY 3   HOW DO YOU FEEL AND WHAT ARE YOU GOING TO DO?

BACKGROUND

This activity is designed to give the participants some insight into the feelings they might have when a parent of a child with a handicap calls to enroll the child and what steps s/he might take to include the child in their program.

OBJECTIVES

1. To increase the participants' understanding of their feelings about children who are handicapped.
2. To have the participants begin to think about what steps s/he might take to include a child with a handicap.

TIME ALLOWANCE

20 minutes

MATERIALS

Chalkboard/chalk or
Overhead/markers or
Flip chart/markers
Paper/pencils
Handout #3: Checklist for Mainstreaming

PROCEDURE

1. Read the following situation to the participants:

   > You are a day care or preschool center director. One day you receive a call from a parent of a child who has cerebral palsy. As a result of the cerebral palsy, the child cannot move about without the assistance of a wheelchair, is nonverbal but uses 20 signs, and is not potty trained. The parent says that a neighbor told her to call the center because her child went to the center and she knew there was an opening.

2. Have them respond on their own piece of paper the following questions:
   *How do you feel? (List 5 feelings)
   *What do you do? (List 5 steps)
3. After the participants have responded on paper, have them share their responses with the rest of the group. Record the responses so that participants can view them. Take time to analyze and discuss the different feelings and steps.
4. Distribute Handout #3 and use as a summary discussion of the activity.

ACTIVITY 4 READINGS ON MAINSTREAMING

BACKGROUND

This activity is aimed at familiarizing the participants with specific literature that has been written on mainstreaming. These articles can be used as a resource for center staff.

OBJECTIVES

1. To introduce the participants to literature written on mainstreaming.
2. To illustrate how the writings can be applied to the participants' own programs.

TIME ALLOWANCE

30 minutes

MATERIALS

Handout #2: Integrating Handicapped Children into Regular Classrooms
Paper/pencils

PROCEDURE

1. Distribute Handout #2.
2. Give participants the following assignment to do before or after reading the article.

   List the points that could be useful on one side of the paper and on the other side tell how they can be applied.

POINT	HOW IT CAN BE USED	CRITICISM
1.		
2.		
3.		
4.		
5.		

3. When the participants are finished with the assignment, have them report on what they had listed as important and why.

SUGGESTED ARTICLES AND BOOKS

Allen R.E. - "Mainstreaming: What have we learned". Young Children, 1980, Vol 35 no. 5, 54-63.

Klein, J.W. - "Mainstreaming the Preschooler". Young Children, 1975, 30, 317-326.

Meisels, S.J. - "First steps in Mainstreaming: Some questions and answers". Young Children, 1977, 33, 4-13.

Morgan, D., & York, F. "Ideas for mainstreaming young children". Young Children, 1981, Vol 36, no. 2, 18-25.

ACTIVITY 5 MEDIA PRESENTATION ON MAINSTREAMING

BACKGROUND
This activity will visually reinforce the value of mainstreaming for the participants. Any movie, filmstrip or slide show illustrating children with different abilities can be used.

OBJECTIVES
1. To show the participants what a mainstreamed day care or preschool might be like.
2. To identify aspects of mainstreamed environments that are important for success.

TIME ALLOWANCE
Depends on audio-visual materials used

MATERIALS
Film/slides or filmstrips and corresponding AV equipment

PROCEDURE
1. Show the film, slide show, or filmstrip to participants.
2. Ask for reactions

SUGGESTED AUDIO-VISUAL MATERIALS
*Integration of Handicapped and Handicapped Preschool Children-Parents' Perspectives. 16 mm film; black and white, sound; 15 minutes. Available from High/Scope Educational Research Foundation, 600 N. River Street, Ypsilanti, Michigan 48197.

*A Child is a Child. 16 mm film; color, sound; 7 minutes. Available from AIMS, 626 Justin Avenue, Glendale, California 91201.

*I'm Just Like You. Part I: Taking it in Stride. Part II: Dealing with the Problem. filmstrips/cassettes; color. Available from Sunburst Communications, 39 Washington Avenue, Pleasantville, New York 10570.

*Feeling Good Comes First: Integrating Handicapped and Non-Handicapped Children. 16 mm film; color; 10 minutes. Available from Outreach, % Salvin School, 1925 South Budlong Avenue, Los Angeles, California 90007.

*Including Me. 16 mm film; color; 40 minutes. Available from University of Illinois, Visual Aids Services, 1325 South Oak Street, Champaign, Illinois 61820.

*Open Up. video-tape; color; 10 minutes. Available from Central Wisconsin Center Regional Disabilities Information Center, 317 Knutson Drive, Madison, Wisconsin 53704.

ACTIVITY 6 PROBLEM SOLVING & VALUES CLARIFICATION

BACKGROUND

Once a center has made a commitment to mainstreaming and has enrolled a child with a handicap there are many situations and problems that may arise. These problems are usually easy to solve, if the staff is prepared and has a clear sense of what they value for their center. The following exercise will give the participants a chance to solve some typical problems that arise and to clarify their values about children who are handicapped.

OBJECTIVES

1. Gain experience in problem solving.
2. Clarify values about programming for children with handicaps.

TIME ALLOWANCE

30 minutes

MATERIALS

Handout #4: Problem Solving & Values Clarification

PROCEDURE

1. Distribute Handout #4
2. Have the participants either respond on paper or orally.
3. Wrap up the exercise by giving participants the opportunity to share personal experiences and relevant ideas.

ADDITIONAL ACTIVITIES

1. Have participants read additional articles on mainstreaming and present points of interest or disagreement.

2. View additional films. Discuss messages given through each film and the audience most appropriate for viewing, e.g., parents, teachers, administrators, etc.

3. Have participants study the laws affecting the education and care of handicapped children. Identify advocacy groups, legislation, implementation and implications for children, parents, communities, agencies, schools, etc.

4. Have the participants visit programs such as Head Start, YMCA programs, and community programs that include children with special needs in their regular activities.

REFERENCES AND RESOURCES

Allen, K.E. Mainstreaming in early childhood education. Albany, New York: Delmar Publishers, 1980.

Guralnick, M. (Ed.). Early intervention and the integration of handicapped and nonhandicapped children. Baltimore, Maryland: University Park Press, 1978.

Meisels, S.J. First steps in mainstreaming. Some questions and answers. Boston, Massachusetts: Media Resources Center, Massachusetts Department of Mental Health, 1977.

II. UNDERSTANDING INDIVIDUAL DIFFERENCES

> We cannot help until we understand.
> We cannot understand until we feel.
> We cannot feel until we become.
>
> The Council for Exceptional Children

We are a long way from being a "barrier-free" society for people with handicaps. Although progress has been made in developing accessible physical facilities, equal educational opportunity and nondiscriminatory employment practices, many silent barriers remain. These less obvious barriers present a much greater obstacle for persons with disabilities: fear, prejudice and ignorance.

The activities presented in this section are each an attempt to help people overcome the personal barriers of fear or ignorance that handicap us all. These activities are generally referred to as "simulation". For our purposes, "simulation" refers to an experiential learning strategy to assist an individual or group toward fuller appreciation of the needs, desires, frustrations, and successes of persons with handicapping conditions. Simulation activities are based on the assumption that we can further our understanding of certain things when we experience them for ourselves. These activities form an effort to increase sensitivity and awareness within each person as they relate to others who are handicapped.

ACTIVITY 1 SAY THAT AGAIN?*

BACKGROUND

Some children have difficulty focusing their attention and understanding and following directions. Tasks that may be easy for other children their age are a source of frustration for children with these problems.

OBJECTIVES

1. To experience a learning task where the level of difficulty is very high.
2. To experience the frustration of a retarded and learning disabled person.
3. To experience being in a position of needing help.

TIME ALLOWANCE

10 minutes

MATERIALS

Plain 8-1/2 x 10 paper and pencils
Paper folding procedure (trainer only)

PROCEDURE

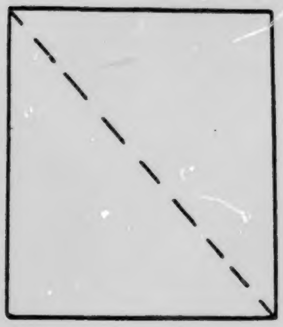
1. Each participant receives a piece of paper and a pencil.
2. The following directions are read seriously with a straight face by the trainer. Begin slowly but pick up speed in talking.

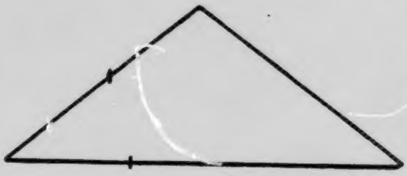
   Fold this square piece of paper in two along the diagnonal. You now have a triangle - (Pause). Mark a point on the diagonal at 1/3 of the distance starting from the left angle, and another at the middle of the triangle's left side. Fold the left angle along the line between the two points so that the left angle reaches towards the right side - (Pause). Now draw a point at the middle of the right side, draw another point at 1/3 of the diagonal starting from the angle of the right, draw a line between those two points, and fold along the line you have just drawn - (Pause). In order to finish the cup, separate the two angles of paper at the top of the old triangle on each side of the cup. Open the cup.
3. Participants will indicate confusion and ask for repetition of instructions. Trainers should repeat directions in a somewhat impatient ("Okay, but try and listen") manner.

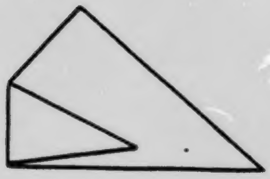
4. Follow-up discussion should relate to the purpose of this exercise. Participants should share their feeling of frustration and then try to relate this to a child who has a learning problem of focusing or following directions. Point out that the lack of visual cues may have added to the difficulty and relate this to learning situations where multiple channels of information (auditory, visual, kinesthetic) may be helpful. Participants should relate their feelings when they had to ask for the directions to be repeated or when the trainer seemed annoyed at their asking.

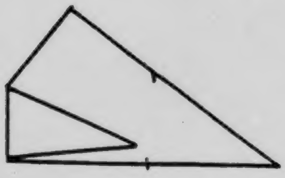
*Source: Ward, M.H., Arkell, R.N., Dahl, H.G., & Wise, H.H. Everybody Counts! A workshop manual to increase awareness of handicapped people. Reston, Virginia: The Council for Exceptional Children, 1979. Reprinted with permission.

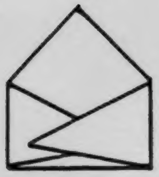
ACTIVITY 1 - PAPER FOLDING PROCEDURES











ACTIVITY 2 FOOT PICK-UP*

BACKGROUND

It is important for us to try and understand our own feelings as they relate to helping people with handicaps.

OBJECTIVES

1. To increase awareness about people with severe physical handicaps.
2. To explore behaviors in helping relationships.
3. To experience adapting to a physical limitation.

TIME ALLOWANCE

15-20 minutes

MATERIALS

One box or waste basket per group
At least 40 unsharpened pencils per group
Index cards, for each group of 10, eight (80%) should have the letter H, two (20%) the letters N-H

PROCEDURE

1. The objectives are briefly discussed.
2. Participants are divided into about even sub-groups, a maximum of 10 participants in each group. At least two groups should participate in the exercise.
3. Participants are asked to sit in a large circle.
4. The boxes or baskets are placed in the center of each sub-group with pencils scattered on the floor.
5. Trainer has participants draw a card.
6. Trainer states, "This is a game. Your task is simply to pick up 4 pencils and place them in the box or basket. The group that has the most pencils picked up at the time the game ends wins. It's that simple. The game ends in 10 minutes or until one team finishes first. Those of you with cards marked H are handicapped. Your special handicap is that you do not have use of your upper limbs. You may take off shoes, or socks. Remember you cannot use your hands or upper limbs but can use any other means. Those of you with N-H cards are not handicapped."
7. Follow-up: H members should share how they felt. Did they resent the N-H members? Did they want the N-H members' help or, if the N-H members offered help, did the H's want to do it themselves? How did the N-H people feel -- uneasy, guilty or perhaps, in this case, envious for not being allowed to do it the hard way?

*Source: Ward, M.H., Arke, R.N., Dahl, H.G., & Wise, H.H. Everybody counts! A workshop manual to increase awareness of handicapped people. Reston, Virginia: The Council for Exceptional Children, 1979. Reprinted with permission.

ACTIVITY 3 MY FINGERS DON'T WORK*

BACKGROUND

Simulating physical handicaps provides a brief experience of a certain handicapping condition. Temporarily restricting our movement may allow us to feel in a small way some of the kinds of frustrations encountered by others whose handicap is permanent.

OBJECTIVES

1. To experience poor fine motor coordination (such handicaps are cerebral palsy, Parkinson's, quadriplegia, etc.).
2. To experience the frustration of not being able to perform simple tasks.

TIME ALLOWANCE

15-20 minutes.

MATERIALS

One pair of work gloves per participant (fingers should be stuffed with tissues)
One pair of scissors per participant
Sheet of paper

PROCEDURE

1. Objectives are briefly discussed.
2. Participants are asked to untie their shoes.
3. Each participant is given a pair of work gloves to put on. (Gloves should be worn on opposite hands)
4. Participants are asked to:
    a. Tie shoes
    b. Fold a paper
    c. Zip up or button an article of clothing
    d. Pick up some money from the floor
    e. Cut paper
5. The trainer might wish to communicate impatience with group's slowness in performing various fine motor tasks during exercise. Later, the group's feeling about the additional "pressure" of the trainer might be discussed related to how a handicapped individual might feel about not performing up to expectations.
6. Follow-up discussion should include discussion of the frustration of not having one's fingers perform as expected.

*Source: Ward, M.H., Arkell, R.N., Dahl, H.G., & Wise, H.H. Everybody counts! A workshop manual to increase awareness of handicapped people. Reston, Virginia: The Council for Exceptional Children, 1979. Reprinted with permission.

ACTIVITY 4 STICK FINGERS* (CAN ALSO BE USED TOGETHER WITH ACTIVITY 3)

BACKGROUND

Simulating physical handicaps that impose limitations to carrying out simple daily tasks may allow us to also experience the frustration of people who live with handicaps each day.

OBJECTIVES

1. To experience the lack of fine motor coordination
2. To experience the frustration of not being able to perform simple fine motor tasks.

TIME ALLOWANCE

15-20 minutes

MATERIALS

Tongue depressors or popsicle sticks
Masking tape
Pencil and lined paper

PROCEDURE

1. Objectives are briefly discussed.
2. A tongue depressor or popsicle stick is taped to the back of each finger on the dominant hand so that the fingers do not bend.
3. Each participant is asked to
    a. Write their name, address, and telephone number on the top, right-hand corner of the sheet of lined paper.
    b. Draw a picture of a person.
4. Follow-up discussion should relate to the problems faced by persons with severe arthritis or other fine motor coordination problems.

*Source: Ward, M.H., Arkell, R.N., Dahl, H.G., & Wise, H.H. *Everybody counts! A workshop manual to increase awareness of handicapped people*. Reston, Virginia: The Council for Exceptional Children, 1979. Reprinted with permission.

ACTIVITY 5 DESCRIBING GAME*

BACKGROUND

Visually impaired people are initially dependent on verbal descriptions to find their way around. This activity should help participants emphasize as well as get practice in making their verbal directions clear and more specific.

OBJECTIVES

1. To increase awareness of the difficulties encountered by visually impaired people.
2. To practice making directions clearer and more easily understood.

TIME ALLOWANCE

15-20 minutes

MATERIALS

Blindfolds
Paper and markers for each pair

PROCEDURE

1. Pair participants and have one of them blindfold another, and pass out paper and markers.
2. Have the seeing person describe a route to a particular place in the building and have the blindfolded person draw a map of what is described, such as a gym, bathroom, library, etc.
3. After the description is completed, remove the blindfold and have both persons try and follow the map.
4. Reverse roles and have the person previously blindfolded try to describe another route.
5. Follow-up the activity with a discussion about what was difficult and what was easy. Discuss ways of improving communication with people who are visually-impaired.

*Source: Ward, M.H., Arkell, R.N., Dahl, H.G., & Wise, H.H. Everybody counts! A workshop manual to increase awareness of handicapped people. Reston, Virginia: The Council for Exceptional Children, 1979. Reprinted with permission.

ACTIVITY 6 STEREOTYPES

BACKGROUND

To be "stereotyped" means to be described as "lacking originality or individuality." People with disabilities are particularly susceptible to being the victims of stereotypes.

OBJECTIVES

1. To better understand stereotyping behavior.
2. To consider stereotypes of people with disabilities in our society.

TIME ALLOWANCE

15-20 minutes

MATERIALS

Chalkboard or large paper to record stereotypic adjectives

PROCEDURE

1. As a group, brainstorm on adjectives that the participants have heard used to describe people with disabilities. It may be necessary to specifically define a disability, such as "Down's Syndrome" to help in brainstorming. The objective here is to get at phrases like, "They're all so cute when they're little." and "They're all so aggressive."
2. After about 5-10 minutes of brainstorming, review list and see if adjectives can be grouped into general categories such as physical attributes, emotional characteristics, social skills, work skills, etc.
3. Ask participants if there are other groups in our society that are stereotyped in the same types of general categories as those above. Examples of stereotyped groups include low-income groups, and racial and ethnic minorities.
4. Follow-up discussion could relate to society's stereotyping of "different" groups and ways of eliminating the use of stereotypes in our own lives.

ACTIVITY 7 WHAT IS A HANDICAP*

BACKGROUND

It is important for people to become more aware of the individual differences among all people, handicapped and nonhandicapped. In a sense, we all have our own handicaps...physical limitations... learning problems...social and emotional difficulties.

OBJECTIVES

1. To help participants deal with general stereotypes associated with the word "handicapped".
2. To obtain a realistic definition of the word "handicapped". This exercise is recommended to close a workshop program since it provides the participants with an opportunity to express new insight towards handicapped people as individuals. Participants learn that handicap is defined by the demands of one's environment.

TIME ALLOWANCE

20-30 minutes.

MATERIALS

Newsprint (or large sheets of paper) numbered 1-10 and taped on the wall about every 5 feet (If this is not possible, activity can be conducted without paper; participants can take a step forward instead of going to a numbered spot on the wall.)

PROCEDURE

1. Each group or sub-group is asked by trainer to define the word "handicap". (This should take no more than 5 minutes).
2. The trainer writes the definitions on a blackboard or on newsprint chart.
3. Trainer then asks participants to stand in the middle of the room and says, "It's nice to see such a large group of non-handicapped normal people."
4. Trainer reads the following list and pauses after each statement to allow participants time to move to the appropriate location.
   "Now I would like everyone wearing eye glasses over at #1."
   "Everyone who is left-handed at #2."
   "Everyone who does not have a Master's degree go to #3."
   "Everyone who does not know how to drive a car go to #4."
   "Everyone who does not know how to swim to to #5."
   "Everyone who does not know how to play a musical instrument go to #6."
   "Everyone who doesn't know a foreign language go to #7."
   "Everyone who can't type more than 60 WPM go to #8."
   "Everyone who doesn't know how to ski (snow or water) go to #9."
   "Everyone who can't do more than 20 push-ups in 5 minutes go to #10."

5. Follow-up discussion questions may include:
Do you still want to keep the definition of handicap you made up?
How many of you "normal" people were found be be handicapped?
How many, multiple handicapped?
Trainer may wish to distinguish the term handicap from "disability".

*Source: Ward, M.H., Arkell, R.N., Dahl, H.G., & Wise, H.H. Everybody counts! A workshop manual to increase awareness of handicapped people. Reston, Virginia: The Council for Exceptional Children, 1979. Reprinted with permission.

ADDITIONAL ACTIVITIES

1. Discuss everyday situations that involve multiple directions that are hard to follow for people who are not handicapped. How could these situations be improved for all people?

2. Discuss ways in which people with disabilities are presented in the media--T.V., movies, literature, advertisements. How do these images increase or inhibit positive attitudes toward people with handicaps?

3. Give participant the opportunity to discuss their own limitations or handicaps and related positive or negative experiences.

4. Have each participant develop a question about a disability regarding employment, transportation, housing, skill training, counseling, medical care, legislation, insurance or wheelchairs and call the toll-free number (within the state of Wisconsin) 1-800-362-9611 to try and obtain the answer. This information service line has been established by the Dept. of Health and Social Services, Div. of Vocational Rehabilitation, as a public service.

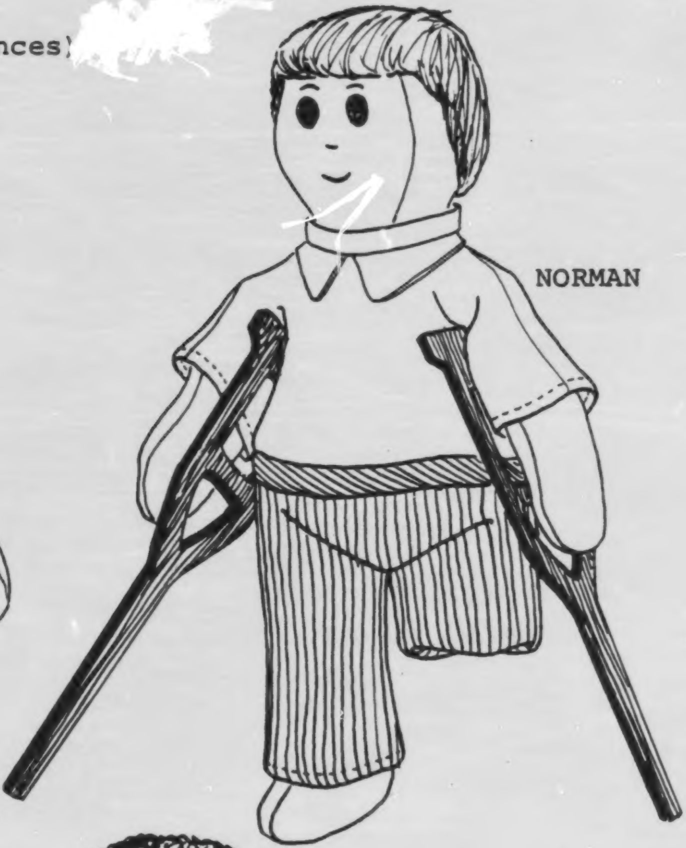
5. Have each participant bring in a children's book related to individual differences. (See Understanding Individual Differences - Additional Activities #5 - Handout 5 in Appendix).

6. Puppetry has been used as a means of increasing awareness and positive attitudes toward people with handicaps and limitations. The "Individual Difference Kids" are puppets that were developed for this purpose (see illustration on following page). Each puppet has a "people package" -- for example, Norman's "people package" consists of blonde hair, brown eyes, a gold shirt, two crutches and brown pants. Each puppet has a people package narrative that emphasizes that similarities and differences exist among all of us. The "Individual Difference Kids" and accompanying narrative can be purchased from:

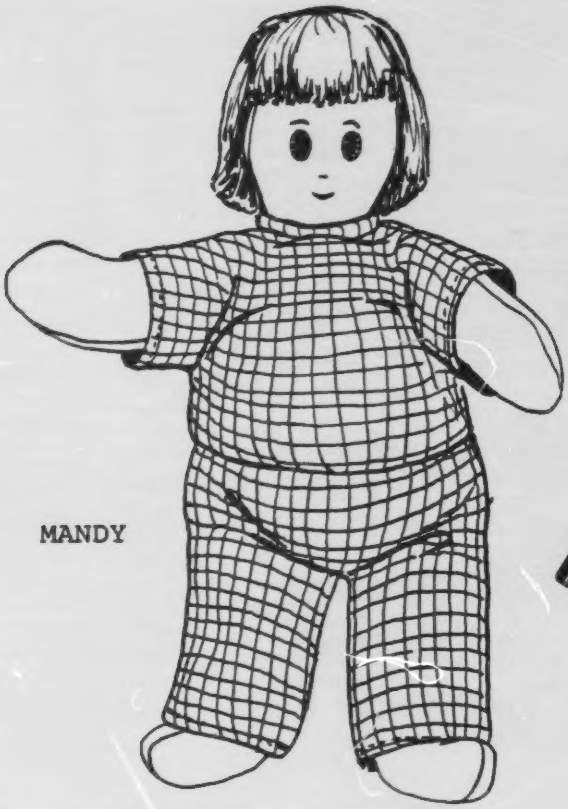
   J. & H. Heart Company
   115 S. 17th Street
   Richmond, Indiana 47374

   It is also possible to make your own individual difference puppets or adapt commercial puppets to create unique people packages!

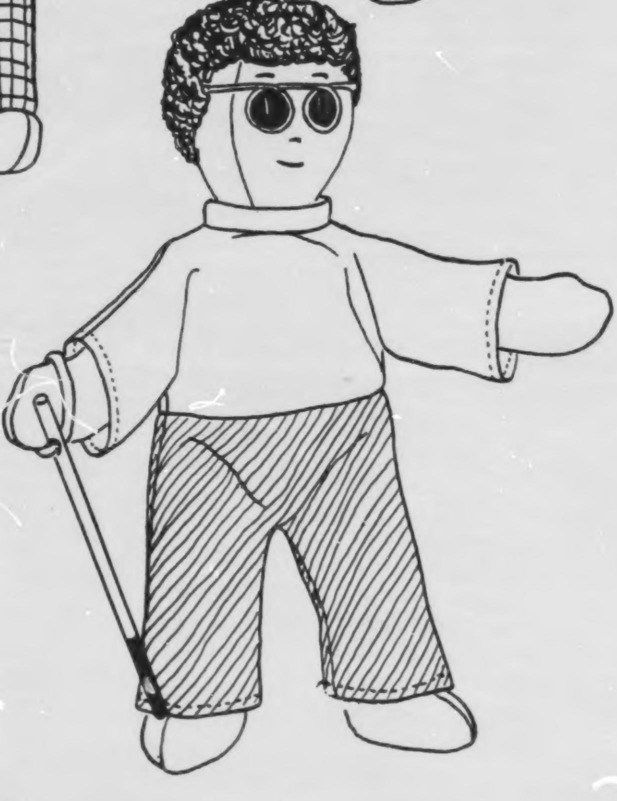
I.D. KIDS
(Kids with individual differences)



NORMAN



MANDY



JASON

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III. HANDICAPPING CONDITIONS

> To care for someone, I must know many things. I must know, for example, who the other is, what his powers and limitations are, what his needs are, and what is conducive to his growth: I must know how to respond to his needs, and what my own powers and limitations are.
>
> Milton Mayeraff

Handicapping conditions include many different kinds of abnormalities and disabilities. Learning about the different handicapping conditions can help day care or preschool teachers to feel more at ease when preparing for mainstreaming in their center. Teachers can build on their knowledge base as children with specific disabilities enroll in their center.

ACTIVITY 1 EVERYONE SQUEEZES OUT GOODNESS

BACKGROUND

This short analogy, "Everybody Squeezes Out Goodness", can be a good beginning activity for a session on individual disabilities.

OBJECTIVES

1. To realize that it may take many different methods to "reach" a child who has disabilities.
2. To stimulate thought and discussion about working with people with handicaps.

TIME ALLOWANCE

5-10 minutes

MATERIALS

Reprint of "Everyone Squeezes Out Goodness"

PROCEDURE

1. Read to participants.
2. Discuss implications with participants.

EVERYONE SQUEEZES OUT GOODNESS*

BY

Barry Moline

Good day, I hope that you brushed your teeth this morning. You know, I'll bet that if there are any toothpaste historians in this world, they could tell you that there has never been a tube of toothpaste thrown out that has been completely empty. In other words, every tube of toothpaste that has been thrown out has had some toothpaste left in it.

You see, somewhere in the life span of a tube of toothpaste someone makes an administrative decision that the amount of resources needed to get any more toothpaste out is too great for what would be obtained. At that point, the tube of toothpaste is thrown out -- and of course, no one throws out a tube of toothpaste with the cap on. The individual then goes to the drawer where the extra tube is stored (there's always an extra tube around somewhere). He looks around the drawer and finds -- no toothpaste. So he reaches way back in the drawer and finds -- no toothpaste. He then searches in the medicine cabinet, in the back of the towels, even in the empty Kleenex dispenser -- still, no toothpaste.

What is he going to do? He has to brush his teeth this morning! His eyes slowly pan the bathroom -- nobody is looking. He steps over to the waste can and quickly bends down to pick up the very same tube that he just threw out. Well, in the 30 to 40 seconds that it took to look for the new tube, that old tube has already grown a full head of hair and has accumulated all sorts of bits and pieces of paper and Kleenex. He has to brush his teeth, so, still checking to see if anyone is looking, he puts the tube under running water and cleans it out -- making sure to get his fingernail in the threads to clean them out.

Now he is ready to start squeezing again. First he tries the two-finger pincher grasp -- starting at the bottom he squeezes up and up to the top. That works, and he brushes his teeth. The next day he wakes to find that same tube in his drawer. Today he tries flattening the tube aginst the counter -- it has a nice round edge. The following morning he has a cheese omelet and then goes to brush his teeth. Same old tube of toothpaste again. This time he rolls the tube up all the way to the top and squeezes with all his might. Finally, toothpaste comes out, and that terrible taste in his mouth is soon gone. After vowing to buy a new tube of toothpaste, he rolls out of bed the fourth day to find that tube again all wrinkled up and out of position. He swears never to let this happen again as he rips open the tube, scraping the toothpaste out.

There are two interesting things about this story. One is that the amount of squeezing that the individual put on that tube is directly related to the amount of toothpaste that comes out. Secondly, and more importantly, the toothpaste that comes out from the most powerful squeeze is of the same quality as the toothpaste that came out from the first squeeze from a new tube.

Everyone in the world is a tube of toothpaste and the toothpaste that comes out is our performance -- our outward actions. Some of us tubes of toothpaste require more squeezing than others. Take people labeled things like retarded, autistic, crippled, deaf-blind, etc. They're tubes of toothpaste just like the rest of us. They might require more squeezing, in the form of more sophisticated teaching strategies and better conditions for learning, but the quality of the toothpaste, when it comes rollin' out of the tube, is exactly the same. That is, they are capable of doing the same kind of quality things as the rest of us. Friendship, work and all the rest.

*Source: Based on a lecture by Dr. Marc Gold, Associate Professor of Education. Reprinted by permission of the Daily Illini, University of Illinois campus newspaper, Richard Sublette, publisher.

ACTIVITY 2 DISABILITIES QUIZ #1

BACKGROUND

This activity can lead to a great discussion. Many times people don't stop to think about people with disabilities as people first. The Disabilities Quiz #1 can be used as an introduction to the disabilities unit.

OBJECTIVES

1. To increase information base of participant.
2. To make participants aware of their own knowledge gaps.
3. To generate interest in the area of developmental disabilities.

TIME ALLOWANCE

20 minutes

MATERIALS

Worksheet
Handout #6: Disabilities Quiz #1

PROCEDURE

1. Distribute the quiz.
2. Allow 5 minutes for participants to complete.
3. Discuss answers with the group, referring to Disabilities Quiz #1 (Trainer's Key).

ACTIVITY 2 - DISABILITIES QUIZ #1 (TRAINER'S KEY)*

1. IS A PERSON WITH A DISABILITY USUALLY SICK?

This question reflects the common misconception that a disability is the same thing as an illness or disease. This implies a kind of medical perspective in which something is "wrong" and needs to be fixed, that a person is sick and must be "cured." In fact, most disabilities are aspects of a person which cannot be "fixed" or "cured", just made less inconvenient by the use of aids and devices or by some medical or educational intervention. A person with a disability can become sick, like anyone; anyone can catch a cold or break a bone. People with disabilities can also recieve treatment for such illnesses. Some disabilities may also make a person more vulnerable to illness. But the disability itself is not an illness to be cured. And most people who have a disability are as healthy as people who do not have disabilities. When children ask if a disabled person is sick, we should say no, and explain that a person's disability is a part of them--just like your blue eyes or your ability to run fast. It is one of the things that makes a person an individual.

2. CAN A PERSON WHO IS BLIND GO TO THE STORE?

Many people think that a person with a disability is usually unable to get around and cope with everyday tasks. Children, in particular, may not be aware of the many ways in which disabled people adapt and adjust to their surroundings in order to remain as independent as possible. If you seldom see a blind woman shopping at the grocery store or a physically disabled man going downtown, it is not because the woman or man are not capable. It is due, in part, to the fact that people with disabilities have been segregated into specialized housing for the elderly and disabled, and to the inaccessibility of most public facilities, including buses, subways, sidewalks and buildings. If there are no ramps at the grocery store or braille numerals on the department store elevator buttons, then obviously it is more difficult for a person with a disability to venture forth. But many people with disabilties do get around, despite the barriers. Also, recent federal and state laws require communities to become more accessible!

Another common misconception is that people with sensory deficits, such as vision and hearing impairments, are disoriented and unable to navigate in their own communities. This is far from true. Men and women who cannot see, for instance, are trained in orientation and mobility skills; they learn to identify locations and acitivities on the basis of sounds and on the basis of the mental maps they have developed through experience in a particular place.

3. IF SOMEONE CAN'T TALK, DO YOU THINK HE'S RETARDED?

Retardation is one of the most difficult disabilities for people to understand. The causes of retardation often are not clear, and the behavior of people labeled retarded varies tremendously. Many people who cannot talk, or who have difficulty talking, may not be retarded at all (and even if a person is retarded that does not mean he or she cannot understand many things). It is a complicated situation. And it may be hard to help children understand, especially when adults do not understand the nature of the disability.

In our society, verbal skill is highly valued and considered the most important sign of intelligence. On a personal level, communication is extremely important to children focused on developing relationships with their peers. It is important for students to understand the concept of receptive and expressive language. Receptive language is what someone can understand when others speak. Expressive is what they can express themselves. There are many people who are unable to talk but who have receptive language; they may have difficulty speaking because of motor problems with their speech organs (cerebral palsy, for example); they may have problems in translating from what they want to say to saying it; they may have a profound hearing loss that has not allowed them to model normal speech; or they may lack motivation or simply fear talking and sharing their thoughts with other people. On the other hand, the problem may not be with the person who has the disability. Have you ever heard of the "myth of multiple disability?" People may assume that a person with limited expressive langauge is limited in what they understand as well. This is often not true. If a person has one disability, it would not be right to assume another one as well.

4. ARE PEOPLE WITH DISABILITIES BORN THAT WAY?

We are all curious about the source or cause of a disability. Children's curiosity often stems from another question, "Can I catch it?" Of course, disabilities are not contagious. Many disabilities are, in fact, evident at birth or soon after, and they reflect a genetic abnormality (e.g., spina bifida, hemophilia), prenatal trauma (e.g., rubella or German measles), or are a result of the birth experience (e.g., blindness as a result of too much oxygen administered to premature infants). Disabilities also result from accidents or illnesses after birth; these include spinal cord injuries, amputations, polio, severe emotional trauma, and so forth. It is important for children and adults to realize that a disability is not "catching". We can do this by explaining the real causes of particular disabilities.

5. DO YOU FEEL SORRY FOR SOMEONE WHO IS DISABLED?

One of the biggest impediments to full acceptance of people with disabilities is the attitude of pity expressed toward them by non-disabled people. Feeling "sorry" for a person who has a disability or feeling gratitude and relief that you do not have a disability may actually create an extra burden that few people with disabilities want or need. These feelings reflect the myth that the life of a person with a disability is a tragedy. The fact is that the majority of people with disabilities have not allowed them to overshadow everything else in their life, but, instead, have tried to come to terms with it as one aspect of life. When other people pity the person with a disability, it makes him or her feel devalued. Most people would prefer respect "like everyone else."

6. CAN PEOPLE WHO ARE BLIND HEAR THE SAME AS OTHER PEOPLE?

People who cannot see are frequently talked to in loud voices, as if they were deaf. This is again the myth of multiple disability--that someone impaired in one area is impaired in others. Ironically, there is another popular myth which may contradict this one. You have seen it on television, namely the stereotyped "blind person" who has extraordinary power of hearing. It is true that a person who has lost one avenue of sensory input probably does become aware of the other senses to a greater degree. It is not true that people who cannot see have "super" hearing. Obviously, severely visually impaired people must rely heavily on hearing and touching to take in information about their environment.

7. IF A PERSON IS RETARDED, DOES IT MEAN THAT SHE WILL NEVER "GROW UP"?

People who are retarded or developmentally delayed do grow up; they change and develop in many ways. If retarded people are treated as eternal children they will have fewer opportunities to achieve independence. People labeled retarded deserve the dignity of risk. They should be offered the same experiences as others to learn skills and to function in the larger community as adults.

8. ARE ALL DEAF PEOPLE ALIKE?

People with disabilities have the same infinite variety of skills and personalities that non-disabled people have. Non-disabled people sometimes assume that all disabled people are alike. But, in fact, people who are called deaf, for example, may have different degrees of hearing: some will use sign language while others will prefer to read lips and speak. Personal interests and qualities will vary, too. Some people who cannot hear are interested in biology or skiing, some are married, and others are single. Like each hearing person, people who cannot hear are unique individuals.

9. CAN A PERSON IN A WHEELCHAIR BE A TEACHER?

Of course, a teacher can be in a wheelchair. Those who think this is not possible may be assuming incompetence and dependence when they see people using aids and appliances. In many ways, the biggest handicap that disabled people may have are the attitudes and expectations of others. Assumed dependence and incompetence are real barriers. It helps to think of devices disabled people use in the same way that we think about bicycles and glasses--technological advances to help us do what we want to do better. Children are often curious about aids and appliances; they want to know what special equipment is for and how it is used. We can satisfy this curiosity by letting children explore the aids and by helping them to problem solve about other gadgets helpful to people with particular disabilities.

10. DO ALL CHILDREN HAVE A RIGHT TO GO TO YOUR SCHOOL OR PROGRAM?

Federal and state laws guarantee to all children with disabilities the right to be educated in regular public schools and in regular classrooms when possible. States may pay for some disabled children to receive their education in private programs, but they must first try to develop programs in regular public schools. This means that students who have very severe disabilities could be in your school either in a regular classroom, resource program or special class. It is important that children see their disabled peers as having the same rights under the law as they do. There is even a law now (Section 504 of the 1973 Vocational Rehabilitation Act) that prohibits discrimination against people because of their disabilities. This law is similar to earlier laws which prohibit discrimination because of race, sex, religion or ethnic background.

While children will come to your classroom with attitudes and stereotypes about people with disabilities, you can have a major effect in changing these. Contact with people who have disabilities will help to destroy the myths. Experiences in simulating the effects of each disability can increase children's awareness of disabilities. Talking and reading as well as participating in group activities, can lead to understanding and acceptance of children who are different and have special needs. In the following pages we will talk about how to "set the stage," how to design a sequence of classroom activities to foster positive attitudes toward people with disabilities and, ultimately, how to teach children to value differences.

*Source: Barnes, E., Berrigan, C., & Biklen, D. What's the difference? Teaching positive attitudes toward people with disabilities. Syracuse, New York: Human Policy Press, 1978. Reprinted with permission.

ACTIVITY 3 DISABILITY QUIZ #2

BACKGROUND
This may be given as a pre- and post-measure.

OBJECTIVES
1. To increase information about disability areas.
2. To generate interest in the area of developmental disabilities.

TIME ALLOWANCE
10 minutes

MATERIALS
Handout #7: Disabilities Quiz #2

PROCEDURE
1. Distribute the quiz.
2. Allow participants to find correct answers while working through ACTIVITY 4 Developmental Disabilities...What are they?

ACTIVITY 4 DEVELOPMENTAL DISABILITIES...WHAT ARE THEY?

BACKGROUND

In order to work effectively with children who are handicapped, a day care or preschool teacher needs to have a basic understanding of their disabilities. Understanding the general nature and characteristics of handicapping conditions can enhance the teacher's understanding of the child's behavior and help meet the child's needs. This activity provides a general overview of the most common childhood handicaps. Teachers are encouraged to obtain further information on these and other handicaps as children with particular handicaps enter their center.

OBJECTIVES

1. To introduce participants to the most common handicapping conditions.
2. To describe each disability in terms of its general definition, incidence and prevalence, causes, and management and prevention.

TIME ALLOWANCE

60-90 minutes

MATERIALS

Handout #8: Disability Description Form (Blank)--one form for each disability discussed

Trainer's Keys to Mental Retardation, Epilepsy, Autism, Cerebral Palsy, and Learning Disabilities

Collection of brochures from local, state, or national organizations (see following page for list of free or inexpensive brochures to be ordered ahead of time for class use)

PROCEDURE

1. Participants are asked to divide into groups and to choose a disability to investigate through the brochures provided by the trainer.
2. Distribute Handout #8: Disability Description Form (Blank) and have each group fill out the form for their disability by using the brochures provided.
3. After the groups have completed their forms, have them share their information with the other participants. Provide each participant with a blank form for each disability discussed.
4. The trainer should supplement the information provided by the participants by referring to the Trainer's Keys or other resources.

ACTIVITY 4 SUGGESTED RESOURCES FOR OBTAINING BROCHURES AND PAMPHLETS

AMERICAN ASSOCIATION ON MENTAL DEFICIENCY,
5201 Connecticut Avenue, N.W., Washington, D. C. 20015

AMERICAN PUBLIC HEALTH ASSOCIATION
1015 - 18th Street, N.W., Washington, D. C. 20036

ASSOCIATION FOR CHILDREN WITH LEARNING DISABILITIES
5225 Grace Street, Pittsburgh, Pennsylvania 15236

ASSOCIATION FOR THE AID OF CRIPPLED CHILDREN
345 East 46th Street, New York, N. Y. 10017

COORDINATING COUNCIL FOR HANDICAPPED CHILDREN
407 S. Dearborn Street, Chicago, Illinois 60605

COUNCIL FOR EXCEPTIONAL CHILDREN
1920 Association Drive, Reston, Virginia 22091

EPILEPSY FOUNDATION OF AMERICA
733 - 15th Street, N.W., Suite 1116, Washington, D. C. 20005

LEARNING DISABILITIES, U. S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
United States Government Printing Office, Washington, D. C. 20402

NATIONAL ASSOCIATION OF THE DEAF
814 Thayer Avenue, Silver Spring, Maryland 20910

NATIONAL ASSOCIATION FOR RETARDED CHILDREN
420 Lexington Avenue, New York, N. Y. 10017

THE NATIONAL ASSOCIATION FOR RETARDED CITIZENS
2709 Avenue E East, Arlington, Texas 76011

NATIONAL ASSOCIATION OF HEARING AND SPEECH AGENCIES
814 Thayer Avenue, Silver Spring, Maryland 20910

NATIONAL INSTITUTE OF NEUROLOGICAL DISEASES AND STROKE
Building 31, Room 8A-08, 9000 Rockville Pike, Bethesda, Maryland 20014

PARENTS OF DOWN'S SYNDROME CHILDREN
c/o Mrs. Marilyn Trainer, 11507 Yates Street, Silver Spring, Maryland 20902

UNITED CEREBRAL PALSY
66 East 34th Street, New YOrk, N. Y. 10016

U. S. DEPARTMENT OF H.E.W., NATIONAL INSTITUTE OF MENTAL HEALTH
5600 Fishers Lane, Rockville, Maryland 20852

U. S. PUBLIC HEALTH SERVICE, NATIONAL INSTITUTES OF HEALTH,
HEW South Building, Room 5312, Washington, D. C. 20201

ACTIVITY 4 MENTAL RETARDATION (Trainer's Key)

Definition: Mental retardation refers to significantly subaverage intellectual functioning. This means that the individual's measured intelligence is lower than 97% of the population. The mentally retarded person is one who, from childhood, develops consistently at a below average rate and experiences unusual difficulty in learning, social adjustment, and economic productivity. For descriptive convenience the range of possible retardation has been divided into four levels--mild, moderate, severe and profound.

Incidence & Prevalence: Mental retardation is the most frequently occurring developmental disability and it is the most widespread of all childhood handicaps. An estimated three percent of the population of the United States--or more than six million individuals--are believed to be mentally retarded.

Causes: Mental retardation can be caused by any condition which impairs development of the brain before birth, during birth, or during the developing years. Among the specified causes are: rubella (German measles) in the mother during the first three months of pregnancy, syphilis, meningitis, toxo plasmosis, RH-factor incompatibility between mother and infant, lead poisoning in young children, and chromosome abnormalities. Inborn errors of metabolism, physical malformations of the brain or other organs originating in prenatal life, and inflammation of the brain associated with childhood measles are also causes of mental retardation. However, the major causes of mental retardation are such nonspecific influences as inadequate diet, inadequate prenatal and perinatal care, and lack of adequate stimulation toward growth and development through learning opportunities.

Management & Prevention: Intervention with children at an early age, including educational programming for the child and supporive services for the family, can minimize and in some cases prevent mental retardation. Preventive efforts also include medical care through pregnancy and birth, avoidance of drugs through pregnancy, and genetic counseling.

ACTIVITY 4 EPILEPSY (Trainer's Key)

Definition: Epilepsy refers to a group of neurological conditions called convulsive disorders. Epilepsy is characterized by an abnormal chemical-electrical discharge of damaged nerve cells in the brain. The discharge is manifest in various forms of physical activity called seizures. The type of seizure activity will vary according to the location and spread of the discharge of the brain. Epilepsy is a symptom of neurological impairment. The general types of seizures are described as follows: (1) generalized seizures -- abnormal discharge takes place throughout most of the brain and include the grand mal seizure and petit mal seizure (Brief lapse of consciousness); (2) myoclonic seizures -- sudden massive jerk of both upper extremities and occasionally the neck and head that may occur in close repetition; (3) partial seizures -- abnormal discharge remains confined to an identifiable area and involves part of the body, e.g., Jacksonian seizure involving upper or lower limbs only, and (4) partial complex seizures -- abnormal discharge arises in the parts of the brain that affect memory, thinking, and reaction to the environment and are also referred to as psychomotor seizures.

Incidence & Prevalence: It is estimated that epilepsy affects two out of every hundred people. Estimates of the prevalence of epilepsy in the U.S. population range from less than one percent to five percent. The Epilepsy Foundation of America states that the prevalence rate is at least two percent or four million Americans.

Causes: The capacity of the brain to develop the abnormal charges that cause seizures is inherent within the brain, and any of us could have seizures at the right time under the right circumstances. The more common causes of epilepsy are head injuries of all kinds including birth injuries, and head injuries later in life. Other causes include anoxia at birth, genetically transmitted disorders, fever, toxic states, allergy, infections, brain tumor, and vascular insufficiency.

Management & Prevention: Although there is no known cure for epilepsy, modern treatment techniques make it possible to obtain complete seizure control in approximately half of all people who have epilepsy. Anticonvulsant medication is the most used treatment for epilepsy. It is estimated that between 80 to 85 percent of the population with epilepsy can achieve enough seizure control to lead essentially normal lives. Preventive efforts include prenatal medical check-ups, periodic medical examinations, and increased safety measures to prevent head injuries.

ACTIVITY 4 AUTISM (Trainer's Key)

Definition: Autism is a life-long disorder that inhibits what a person sees, hears, or otherwise senses. The term is used to describe a cluster of behaviors exhibited from an early age and include the following characteristics: (1) slow development or lack of physical, social, and learning skills; (2) absent or delayed speech and language; (3) abnormal responses to sensations; (4) abnormal ways of relating to people, objects, and events, and (5) repetitive movements, such as hand twisting, prolonged rocking and spinning, and head banging.

Incidence & Prevalence: The National Society for Autistic Children estimates that autism occurs in approximately four to five out of every 10,000 children. The incidence is about 12 in 10,000 when children are included who have some autistic-like characteristics and require similar services. Autism is two to four times more likely in boys than in girls. There is no known relationship with the ethnic background, income level, educational level, or child-rearing practices of the family.

Causes: At present the precise cause of most cases of autism are unknown. There appear to be several kinds of autism, each with a distinct neurological base. Current research points to a physical cause affecting the parts of the brain that deal with language and organization of information perceived by the senses. This may cause a disturbance in the balance of chemicals to the brain and affect nerve impulses. Environmental hazards that cause brain damage, such as disease or lack of oxygen at birth, have been linked with the onset of autism.

Management & Prevention: Although autism's causes remain unknown, intervention strategies can help minimize the effects of the disability. Educational programs that are highly individualized and structured have proven helpful, including social and language skill development and behavior management. In cases where abnormalities in metabolism can be identified, diet and medication may be helpful. Counseling and other supportive services are often recommended for parents of children with autism.

ACTIVITY 4 CEREBRAL PALSY (Trainer's Key)

Definition: Cerebral palsy is the general term applied to a group of disabling conditions resulting from damage to the developing brain. It may occur before, during, or after birth and results in loss or impairment of control over voluntary muscles. The six major types of cerebral palsy are: (1) spasticity--the most frequently occurring motor characteristic of cerebral palsy characterized by muscle spasms; (2) arthetosis--characterized by constantly recurring, slow involuntary writhing movements of the arms and legs, occurring in about 25 percent of the population with cerebral palsy; (3) ataxia--disturbed sense of balance and depth perception, occurring in about seven percent of the population with cerebral palsy; (4) tremor--characterized by fine tremors, occurring in one to five percent of the populations with cerebral palsy; (5) rigidity--muscles contract slowly and stiffly, leading to clumsiness, occurring in about seven percent of the population with cerebral palsy; and (6) mixed--two or more of the above types of cerebral palsy. Communication difficulties may also accompany other motor problems.

Incidence & Prevalence: Cerebral palsy is the most common physical handicapping condition of childhood, with an incidence of about one in every 200 live births, or approximately 15,000 babies each year. The United Cerebral Palsy Association indicates that 750,000 persons in the U.S. have cerebral palsy.

Causes: The common causes of cerebral palsy include prenatal causes such as drugs and x-ray irradiation that interfere with normal development of the fetus. Also, perinatal causes such as birth trauma and anoxia, and postnatal causes such as respiratory distress and infections may result in cerebral palsy. In approximately twenty percent of the cases, no cause can be established.

Management & Prevention: Intervention for the person with cerebral palsy is aimed at improving function, preventing malformation during growth, and helping the individual function at an optimal level within his/her limitations. Proper exercise and positioning can help improve a child's coordination and muscle control. For individuals with speech difficulties, communication devices can greatly enhance their intellectual and social development. Adaptive equipment such as speaker phones and electric wheelchairs can help individuals with cerebral palsy meet their physical needs and contribute to their independence. Preventive strategies for cerebral palsy include good health care before pregnancy and during the pre-, peri-, and post-natal stages of growth and development. Good health care during early childhood is also an important preventive measure.

ACTIVITY 4 LEARNING DISABILITIES (Trainer's Key)

Definition: A learning disability is defined as a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written. Difficulties in listening, thinking, spearking, reading, writing, spelling, or math may be the effect of the learning disability. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and aphasia. The term does not include children who have learning problems which are primarily the result of vision, hearing, or motor handicaps, or mental retardation, or of environmental, cultural, or economic disadvantage.

Incidence & Prevalence: The National Advisory Committee on the Handicapped estimated that there are approxmimately two million children with learning disabilities. It has been estimated that up to ten percent of any school population have learning disabilities. However, the number of students with real learning disabilities is probably closer to three percent.

Causes: Emphasis on the many possible causes of learning disabilites has changed over the years. Early in the development of the learning disability concept, many specialists thought that the child's problems resulted from an internal physical deficit e.g., brain damage or neurological impairment. Others believed that learning disabilities resulted from deficits in the psychological learning processes, e.g., attention, perception, memory, etc. The current emphasis is on an educational model that acknowledges differences in causes and focuses on task analysis of the skill to be learned and instructional techniques for teaching the skill. There is also some attention to environmental factors that may have some relationship to learning disabilities, such as nutrition, fluorescent lighting, fluoride, radiation, aerosols, and auditory pollution.

Management & Treatment: A number of instructional techniques have been developed to address specific learning disabilities. Environmental interventions such as changing the diet or physical environment of the child with learning disabilities are also under study. Drug therapy continues to be used, including amphetamines, stimulants, tranquilizers, and antidepressants. The extent to which drug use is beneficial remains inconclusive. Difficulty in identifying causes for learning disabilities has resulted in few established strategies for prevention.

ACTIVITY 5 SPECIAL TECHNIQUES FOR WORKING WITH CHILDREN WHO HAVE DISABILITIES

BACKGROUND

Simple hints can often be helpful when encountering unfamiliar disabilities.

OBJECTIVES

1. To provide practical information about handicaps.
2. To point out different techniques to be used when working with various disabilities.

TIME ALLOWANCE

30 minutes

MATERIALS

Chalkboard/chalk or
Overhead/markers or
Flipchart/markers
Paper/pencil
Handout #9: Special Techniques for Working with Children with Handicapping Conditions

PROCEDURE

1. Divide participants into groups.
2. Allow 8 minutes for groups to think of helpful points to consider when dealing with:
   - Health impairments
   - Emotional disturbance
   - Mental retardation
   - Orthopedic handicaps
   - Speech and language difficulties
3. List helpful hints on chalkboard as they are discussed.
4. Distribute Handout #9 for future reference.

ADDITIONAL ACTIVITIES

1. Visit a program that has children who are visually impaired. Find out all you can about the materials used for teaching these children.

2. Visit an early childhoood special education program. Schedule time for a visit with the teacher.

3. Visit an institution. Ask participants to write down the positive and negative aspects of institution life.

4. Learn how to change batteries and adjust a hearing aid. Invite a community member to speak on the topic.

5. View a good series of filmstrips on disabilities such as:
    Children With Handicaps: What Makes Them Special?
    This is available from Parent's Magazine Filmstrips
        Distributed by PMF Films, Inc.
        Box 1000
        Elmsford, New York
        10523
    Ask for 30 day approval period - no obligation.

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IV. WORKING WITH COMMUNITY RESOURCES

> Reach out and touch somebody's hand.
> Make this world a better place if
> you can.
>
> Ashford and Simpson

The key to success when serving children with special needs is to identify and cooperate with community resources whenever possible. Because mainstreaming is a new concept within day care and preschool settings, it is especially important that community resources work together and be supportive of mainstreaming efforts.

ACTIVITY 1 WHAT IS IN A RESOURCE DIRECTORY?
or (IF ONLY I HAD KNOWN ABOUT THIS BEFORE)

BACKGROUND

Many cities and counties have resource guides or directories. This activity can help day care center staff become familiar with the services for children who are handicapped or delayed.

OBJECTIVES

1. To familiarize the participant with services and resources for children with needs .
2. To examine a community resource directory.
3. To make contacts with individual resources and gain more information than is provided in a directory.
4. To learn about community resources from a class discussion.

TIME ALLOWANCE

Participants will need time outside of class for preparation
Depends on the number of resources and/or students in the class

MATERIALS

Resource directories

PROCEDURE

1. Remove the pages from your local community resource directory that relate to serving chldren with special needs.
2. Instruct participants to select a resource that they are unfamiliar with.
3. Instruct participants to contact the resource and explore their services.
4. At the next class meeting the participants will have time to share their individual findings.

ACTIVITY 2 MAKING A RESOURCE DIRECTORY (SPECIFIC TO SPECIAL SERVICES FOR CHILDREN)

BACKGROUND

If a resource directory doesn't exist in your county, it will be helpful for the participants to compile one for their own use in serving children with special needs.

OBJECTIVES

1. To create a simple resource directory for day care center or nursery school use.
2. To share information with other participants and compile information.

TIME ALLOWANCE

Participants will need time outside of class for preparation 20-30 minutes for class discussion.

MATERIALS

Handout #10: Community Resources for Children with Special Needs

PROCEDURES

1. Pass out Handout #10 for the participants to fill out. Each participant may wish to complete several.
2. Suggestions may be provided to give participants added direction.
3. Duplicate copies of completed sheets for each participant.
4. The trainer will then lead the class in discussion of the resources.

ACTIVITY 3 RESOURCE SPEAKERS

BACKGROUND
Community resources can make a valuable contribution to the success of mainstreaming. Inviting people to speak to the class will help to establish linkages between the participants and resources in the community.

OBJECTIVES
1. To increase awareness of community resources.
2. To gain specific information on selected topics.
3. To meet people that represent various agencies that deal with handicapped or delayed children.

TIME ALLOWANCE
60 minutes per speaker

MATERIALS
Suggested speakers are:

1. Local Early Childhood Exception Educational Needs teacher, public school
2. Physical therapist
3. Occuaptional therapist
4. Language clinician or speech therapist
5. Head Start teacher
    a. Special needs coordinator
    b. State handicapped advocate
6. Birth - Three project staff (Infant and Toddler special education programs)
7. Wisconsin Division of Community Services Licensing and Certification Specialists
8. Handicapped advocacy groups
9. Community Coordinated Child Care staff member
10. Mental health staff
11. Social workers
12. Wisconsin Association for Retarded Citizens staff member
13. Epilepsy Center staff member
14. Muscular Dystrophy Association staff member
15. Parent of a handicapped child.
16. United Cerebral Palsy staff member
17. Society for Autistic Children staff member

ACTIVITY 4 IT'S GREEK TO ME
or
JARGON SCHMARGON - JUST SPEAK TO ME IN MY NATIVE TONGUE
OR
MAKING SENSE OUT OF PROFESSIONAL JARGON

BACKGROUND

Once day care staff have begun to use community resources and consultants, the need for communication between early childhood and special education professionals increases. In order to increase understanding, a glossary of terminology will be useful.

OBJECTIVES

1. To increase understanding of terms, jargon, and expressions used in the field of early childhood special education.
2. To improve communication gaps between day care staff and special education staff.

TIME ALLOWANCE

30 minutes

MATERIALS

Handout #11: Glossary of terminology
Handout #12: Disabilities Interpretation Worksheet

PROCEDURE

1. Direct the participants to decipher the messages on Handout #12.
2. Pass out the Glossary of Terminology for participants to refer to.
3. The Glossary of Terminology will also be a helpful aid for future reference.

ACTIVITY 5 HOW TO GET AND USE HELP

BACKGROUND

Once you know who to call for assistance you may ask yourself the following questions: When do I need help and what can I expect from consultants and other support service providers?

OBJECTIVES

1. To increase participants' awareness of a consultant's role.
2. To provide participants with information concerning when to ask for outside assistance.

TIME ALLOWANCE

10 minutes

MATERIALS

Handout #13: Consultant in Day Care

PROCEDURE

1. Begin a discussion about when a center might need to bring in a consultant.
2. Ask participants to list all the things that they think a consultant could do for them.
3. Follow up with discussion and handout.

V. UNDERSTANDING FAMILIES

> Each child is different; no child's future is assured and all parents fear for themselves and their children. All families must learn to deal with anger, both justified and unjustified; with uncertainty and with the inevitable. Even the best endowed child strains his or her parent's relationship, a disability only intensifies the strain as it does other family problems. The pain of one child's disability reshapes every life in unexpected ways. Nonetheless, individuals endure.
>
> Helen Featherstone

In order to care for and enhance the development of a child with a handicap, it is crucial to understand the impact having a handicapped child has on a family. The following activities will serve to "tune in" child care workers and teachers to the types of emotions and problems related to bringing up a child with a disability. This unit will allow the participants to develop some strategies to respond to problems and emotions of the family members.

ACTIVITY 1 "THEIR STORIES"*

BACKGROUND

This activity is one where the participants are assigned two books to read that relate two different families' stories. The trainer may want to choose to assign only one book and the other for optional reading.

OBJECTIVES

1. To familiarize students with the emotions and dynamics of families who have a handicapped child.
2. To familiarize students with the kinds of resources and professional help families turn to and the types of responses they receive.

TIME ALLOWANCE

Enough time to read the books at home

MATERIALS (suggested books)

Yesterday's Child by Helen Brown (Signet Classics, 1977)
Son Rise by Barry Neil Kaufman (Warner Books, 1979)
other books that relate the experiences of families with children with handicaps

PROCEDURE

1. Distribute books or have pariticpants purchase them.
2. Direct participants to note the following things while reading the books:
    a. Emotional responses of parents and excerpts from the books that reflect the emotions; for example (Yesterday's Child):

       Anxiety: "Was I going to be a perpetual nursemaid to a perpetual infant?"

       Sadness "My mother sat beside me and we wept for my tiny child."

       Guilt: "I realized what a burden she had become. And as soon as I realized that, I felt guilty. I tried to put it out of my mind."

       Happiness-Pride: (In regards to her walking) "The three of us laughed and cried treasuring one of our happiest moments."

       Loneliness: "I had never felt so alone. No one had any advice to offer."

       Love: "The ties that bind us together are as strong as between any mother and daughter, and I was driving to find the best possible life for her.

b. Resources parents contacted and the responses they received; for example (Son Rise):

Other Parents: They found out from parents that most had initiated a search for answers and information and received little or no help. They would have to search on their own.

Institute in Philadelphia, Brooklyn Institute, Nassau County Institute: None of them would see Raun until he was much older, and then only a "maybe".

Developmental Check-up and Examination: They received no new information. However it did help them to see Raun's progress from his previous check-ups.

Calls to Speech and Language Therapists: The Kaufman's used the therapists as consultants in Raun's language development.

Health Center (2nd visit): They were told because of Raun's age and current capabilities, they would not be able to help them.

Teacher-Therapists: These high school girls were very helpful in the implementation of Raun's program.

Friends: Their friends were concerned, interested and willing to help in any way.

Director of Out Patient Program: The doctor was extremely impressed and felt he had much to learn from the Kaufmans.

3. Discuss the books. Conclude discussion by preparing a list of additional resources or help families could have used, e.g., parent support group.

*Source: This activity was adapted from a course entitled "Working with families" offered by Dr. Betty Vincent, Department of Behavioral Disabilities, University of Wisconsin-Madison.

ACTIVITY 2 IT COULD BE YOU...*

BACKGROUND

Parent involvement plays a vital role in the success of an early childhood program. In order for parents to openly discuss pertinent information, concerns, and questions with teachers and child care workers, they need to feel comfortable communicating with the teachers and staff. In this process of getting acquainted and establishing relationships, it is important for the teacher to be aware of the parents' feelings. The following exercise is designed to help lead the participants through some of the feelings a parent feels at the time of diagnosis.

OBJECTIVES

1. To familiarize the participants with the feelings parents have toward their handicapped child.
2. To help the participants more fully understand the source of these feelings.

TIME ALLOWANCE

30 minutes

MATERIALS

Paper/pencils
Trainer's reference (optional): Emotional Aspects of Parenting

PROCEDURE

1. Direct the participants through the following activities:
   Step 1: List 10 reasons why people get married.
   Step 2: List 10 reasons why people have children.
   Step 3: Let's pretend you have met someone you love and you are getting married. Let's say that you both want children. What are your expectations for your child? What do you want him/her to be like? (10 characteristics)
   Step 4: You are 8 months pregnant. Since the due date is close, you are planning what you might do with the baby in the first week after the child is born. (10 activities).
   Step 5: The time has finally arrived. After months of planning and preparation, you begin labor and are taken to the hospital. You deliver a 6 lbs. 10 oz. baby boy. You are wheeled into your own room to recover and wait for your husband to return from calling relatives about the good news. Your doctor comes back into your room. He says, "There is a problem with your baby; he has Down's Syndrome". Please list your reactions and feelings at this time. (10 feelings).

2. After you have finished the five steps, start with the fifth step and have the participants share their answers. (e.g., mad, guilty, shocked, etc.)

3. Go back to Step 4. Ask participants to share activities that they thought would be affected by having a child with Down's Symdrome (e.g. taking pictures, calling relatives, being happy, etc.)

4. Go back to Step 3. Ask to participants to share expectations that they thought would be affected (e.g., smart, popular, healthy, independent, etc.)

5. Go back to Step 2. Ask the participants to share reasons for having children that they though would be affected (e.g., please their parents, keep the marriage together, etc.)

6. Go back to Step 1. Ask the participants to share reasons for people marrying that they thought would be affected (e.g., to have children, for security, etc.).

7. Ask participants to think about the information and impressions gained from this exercise that will help them relate better to parents of handicapped children. Ask participants to share their insights.

*Source: This activity was adapted from a group exercise that was developed by Project Rhise Outreach, Children's Development Center, Rockford, Illinois.

(TRAINER'S REFERENCE)

EMOTIONAL ASPECTS OF PARENTING*

by
Joan Burns

Waisman Center on Mental Retardation and Human Development
University of Wisconsin - Madison

Presentation at Educational Advocacy Meeting - Tuesday, March 8, 1977.

As a new parent of a handicapped child - I didn't talk with anyone much about how I was feeling. Actually my husband and I talked a great deal about our disappointments for our child's sake and our own hurts but some of the feelings I had were, I thought, so awful that I couldn't admit them even to him. I guess my "guilt" feelings, which all parents of handicapped children, theoretically have, were not the guilt for producing the child and her handicap, but rather guilt for some of the ways I felt toward her and toward nature for bestowing this problem on me. I suppose my reactions could have been categorized into anger, self-pity, and grief for her but overall I felt guilty for having all of these feelings and reactions.

One of the things that helped me deal with my feelings retrospectively occurred several years after the birth of my profoundly retarded daughter. When I returned to school and began to prepare for a career in mental retardation I became aware of some of the literature about parents of retarded children and at long last realized that I hadn't been so abnormal after all.

Most of the literature which considers the emotional implications of a handicapped child on the family deals with mental retardation. My personal and professional experience has also been primarily with mental retardation but I have compared notes on this subject with parents of other disability groups and find a striking similarity in parental reactions to handicapped children.

In order to think about what kinds of reactions parents have when their child is born with a serious birth defect we must consider what it is that children mean to parents. David Rychman and Robert Henderson have drawn together a review of the literature and prepared a paper entitled "The Meaning of a Retarded Child for His Parents: A Focus for Counselors." The authors have extracted 6 areas of meaning of children for parents and discussed how these are affected when the child is mentally retarded.

It is not intended to imply that all parents experience all 6 of these "meanings of children to parents" but I think some of them are meaningful to each of us who has experienced "parenthood".

The six meanings of children to parents are:

1. The parent views the child as a physical and psychological extension of himself.

   This concept has many ramifications to the parent when the child is defective.

Many of the authors in this area point out the almost universal feeling of inadequacy of parents when they find that their child is defective.

2. The child is a means of vicarious satisfaction to parents; that is, parents expect to experience satisfaction of their wishes and desires through life experiences of their children. Some of the core problems of parents with handicapped children are disappointments.

3. Parents can "transcend" death through their child and thereby desire some measure of immortality.

   This point is not well defined in the literature but may be implied by parents' concerns that their children have a better "chance" in society or life than the parents, and the hoped-for-climb in status which parents may have for their children.

   A handicapped child may not be able to accomplish these goals that his parents have for him.

4. A fourth area of meaning of children for parents in the concept of a personalized love object - this area is tied in with the discussion of guilt.

   There is general agreement in the literature that parents feel guilty, at least in parent, because they do not love their defective child as wholeheartedly as they believe they should. Inherent in this guilt is the element of rejection, that is failure to love the chld accompanied by anger and frustration.

5. A 5th meaning of children is the parental feeling of worth in meeting the dependency needs of the child.

   This is most often expressed in terms of over protectiveness which is a means of compensating for the child's handicap and thus achieving some satisfaction from the child. Another explanation of this refers to the "chosen people" or "martyr" syndrome in which parents maintain some feelings of self worth through extreme devotion to the needs of a handicapped child.

6. Negative feelings about the limitations and demands of child rearing are a 6th area of meaning of children to parents.

   Handicapped children are an added burden to parents. The demands and limitations on parents are realistically increased when rearing a handicapped child.

(Effect that the birth of a handicapped child has on parents)

All of the areas described (except #6) are very closely connected with the self-concept of the parent.

When a parent becomes aware that his child is handicapped, a number of rewards which the child may bring to the parent are denied and his self-concept may be severely shaken. The parent can be expected to react to these threats and loss of rewards. To continue to react in the usual and culturally expected pattern would be somewhat abnormal for parents of a handicapped child, especially during the initial recognition stages.

How might parents be expected to react - it seems they have 2 alternatives - They can either 1) change their method of viewing the child and/or 2) develop ego-defense mechanisms to insulate against the threats of a defective child. The first takes some time to accomplish and the second is probably more common in early stages.

It is unrealistic to expect parents to be happy about having a handicapped child and therefore it would appear reasonable to assume that there are limits to the extent to which a parent can emotionally respond to the handicapped child in the same manner as he would to a normal child.

It is hypothesized that there is a point beyond which the parent cannot healthfully involve himself emotionally with a handicapped child. There is a limit to the stress that an individual can handle and once past that point the individual will develop defense patterns which allow him to cope with the situation. It should be pointed out that the stress parents can handle and the way in which they handle it varies and is somewhat dependent upon the parents own nature, the nature of the handicap and various family backgrounds.

Many authors have written about the various stages one goes through in a reaction to crisis. One review that has been acknowledged and used in dealing with families of mentally retarded persons was based on Farber's theories as described in his paper dealing with "Perceptions of Crisis and Related Variables and the Impact of a Retarded Child on the Mother" (1960) and was presented in an article by Wolfensberger and Menolascino entitled "A Theoretical Framework for the Management of Parents of the Mentally Retarded."

The authors suggest that parents experience three distinct stages of emotional response following the birth or diagnosis of a handicapped child.

The first stage described is called Novelty Shock. This is very natural response that occurs when parents learn that their child is "not normal" - this is a time for lots of ego-defense mechanisms to develop as we discussed before and I feel a very crucial reaction to crisis which must be "lived-through" or "worked through" emotionally before one can expect to "get on with" whatever the child or families needs may be. I see it as a "healthy" reaction to crisis - as long as one progresses through it and doesn't get hung up too long in that stage - Novelty Shock is intense and varies in duration but once it is worked through it can be expected to be non-recurrent.

A second stage of response has been called *Value Conflicts*. This is the stage during which parents must work to change their view and expectations of the child in light of society's imposed expectations of "normalcy". This tends to be of longer duration than novelty shock but again - once resolved it is not likely to again become a major source of conflict.

The third stage of emotional response has justifiably been called - *Reality Stress* - this is the term used to convey the recurring - ongoing probelms of caring for a handicapped child. I think I would add here a bit about Olshansky's notion of *Chronic Sorrow*. He points out that parents of severely and profoundly retarded children suffer a recurring and chronic sorrow about their child's handicap and episodes of distress related to this condition flare-up at different life stages of the child when some new management problems present themselves. These changes might be reaching school age, entering puberty, or needing new medical intervention - all of which are times when parents are reminded of the distressing differences their child has and problems which demand special arrangements. Obviously *Reality Stress* is a continuous and/or recurring phase and cannot be set aside- but must be dealt with anew each time some major or even minor crisis in daily living occurs.

I think that when professionals dealing with parents of handicapped children accept the fact that these reactions are normal and healthy and learn to recognize where parents are in dealing with their emotional responses they will become more helpful with the problems they are trained to deal with.

*Reprinted with permission.

ACTIVITY 3 DEVELOPMENTAL CRISES PERIODS

BACKGROUND

Parents of handicapped children may experience difficult emotions long after diagnosis of the child's handicap and the initial adjustment period. For many parents, feelings of shock, guilt, and bitterness are never totally resolved and acceptance of their child's handicap is never fully complete.

OBJECTIVES

1. To identify occasions during the child's life that are associated with increased emotionality of parents.
2. To understand that parents may continually experience emotions related to their child's handicap that may create stressful family situations.

TIME ALLOWANCE

15 minutes

MATERIALS

Chalkboard/chalk or
Overhead/markers or
Flip chart/markers

PROCEDURE

1. Ask participants to identify critical periods in an individual's life that might create a "developmental crisis". By "developmental crisis" we mean those early life events that focus on the discrepancy in development between the handicapped child and the child without handicaps. These crises may evoke feelings from parents such as guilt, resentment, sadness, or despair. Record the developmental crises identified by the participants.
2. Compare the developmental crises identified by particpants with those identified by Dr. Lynn Wikler (University of Wisconsin - Madison):
    - *Diagnosis
    - *Should be walking
    - *Should be talking
    - *Younger sibling surpasses the achievements of the handicapped child
    - *Beginning of public school
    - *Discussion of placement and/or actual placement out of the home
    - *Any time family has problems that necessitate a transition to professional resources for management
    - *Puberty
    - *21st birthday - school relinquishes its role of caretaking and educating
    - *Guardianship
3. Expand the developmental crises list developed by participants if necessary.
4. Discuss the implications of developmental crises for the young child in day care or preschool.

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ACTIVITY 4 SIBLINGS COUNT TOO!

BACKGROUND

Siblings strongly feel the effect of having a brother or sister who is handicapped. The emotions experienced by parents of a child with handicaps may also be shared by other children in the family. They will need to understand their role in the family, a role that may have been changed by the presence and and needs of their handicapped brother or sister. For child care workers and teachers it is important to remember the needs of siblings, especially if a sibling is in the same program as the handicapped brother or sister.

OBJECTIVES

1. To familiarize participants with the feelings of siblings of children who are handicapped.
2. To increase understanding of the problems of siblings of children who are handicapped.

TIME ALLOWANCE

15 minutes

MATERIALS

Paper/pencils

PROCEDURE

1. Read the following narrative to the participants:
   You have just turned three. You are speaking in three and four word sentences. You can point to pictures that are the same or different and you can name many parts of the body. You are sensitive to others' feelings and reflect the moods of your parents. You like to help with household tasks and you often imitate Mom and Dad's activities around the house. You have a strong drive to meet with their approval. Today, Mommy cam home from the hospital with the new baby. You didn't get to see little Johnny very long because Daddy said, "Johnny is sick," and he closed the bedroom door. You did see that Johnny looked sort of funny. He had some tubes in his nose and in his tummy. He looked very sick. When relatives came to see the new baby, they went away looking very sad. Someone said, "He's not breathing very well".
2. Divide into groups of 3 or 4 to discuss and record answers to the following questions related to the narrative:
   * How do you feel? (Examples: rejection, anger, fear)
   * What do you think? (Examples: Will I get it? Why are my parents always with him?)
   * What questions would you ask? (Examples: What's wrong? Do you still love me?)
3. After 15 minutes have the groups come back together to present and discuss their answers.
4. Wrap up activity by discussing strategies for involving siblings in services to families with handicapped children.

ADDITIONAL ACTIVITIES

1. Follow ACTIVITY 4 by having the participants read a short story relating the experiences of a sibling of a handicapped child, such as "Destroying Angel" by Eric Cameron (found in Landau, E. *Child development through literature*. New York: Prentice-Hall, 1972). After reading the story ask the following discussion questions:
   * Describe the conflict or emotion Paul felt about his brother's handicap; document incidents that lead to your impressions.
   * Discuss why it might be embarrassing and time consuming to have a brother who is retarded.
   * Discuss how parents and professionals can relieve the burden for the siblings.

2. Have a parent of a disabled child come to a training session and speak to the class about his/her family.

3. Visit a parent meeting, possibly through your local Association for Retarded Citizens or Epilepsy Association.

4. Have a family counselor or Parent Effectiveness Trainer (P.E.T.) come to class and discuss listening and counseling techniques.

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VI. DEVELOPMENTAL APPROACH TO ASSESSMENT AND PROGRAMMING

> Anyone who touches the lives of the young
> is clearly responsible for their destiny.
> Each of us has both a healing and a hurting
> power.
>
> Segal & Yahares

Human development can be defined as a change in an individual's function or capacity in any one or combination of four interacting areas or "developmental domains": physical, emotional, social and intellectual. Development involves changes from simple to more complex behaviors. Behaviors usually occur in some predictable sequence over time. For example, children communicate first with cries, then words, followed by phrases and sentences. Increasingly complex language patterns and meanings are associated with increasing chronological age. Similarly, children's mobility progresses from crawling and cruising to walking alone.

By watching the development of many children over time, average ages or age rates for achieving certain skills or "developmental milestones" have been recorded. Age-specific lists of these milestones form a guide to normal development. Most of this information has been collected on children who were not handicapped. Since we know much less about the developmental progress of children with handicaps, normal developmental milestones (also called "developmental pinpoints") are recommended by many as a best guess estimate of developmental progress for children with handicaps.

The activities presented in this section are designed to familiarize the participant with normal developmental milestones and the use of a developmental approach to assessment and programming for young children with handicaps.

ACTIVITY 1 DEVELOPMENTAL CHECKLIST

BACKGROUND

Developmental assessment is conducted by observing the child's activities in either a structured or unstructured situation and comparing specific behaviors with behaviors known to be representative of developing infants and young children of particular ages. Achievement of a certain behavior or skill is measured in terms of normal developmental milestones that reflect the average rate of developmental achievement.

OBJECTIVES

1. To become more familiar with a developmental assessment approach.
2. To practice using a developmental checklist.

TIME ALLOWANCE

30 minutes

MATERIALS

Handout #14:	Developmental Checklist
Handout #15:	Case study description

PROCEDURE

1. Distribute Developmental Checklist and case study description to each participant.
2. Review the objectives of the activity.
3. Direct trainees to carefully read the case study description and then go over the Developmental Checklist in order to arrive at Steven's developmental ages for each of the domains listed on the cover sheet of the Checklist. Information on Steven is limited but direct trainees to arrive at approximations of where he is functioning based on the case study description. Record developmental ages in Column 1, labeled "1st Evaluation."
4. After everyone has completed their assessment, discuss the developmental ages the group obtained.
5. Discuss the use of a Developmental Checklist such as this one in preschool and day care centers. Ask for other examples of assessment tools that participants have found useful.
6. Follow-up Activity 1 with Activity 2.

NOTE: One of the difficulties in using a developmental pinpoint approach is that there are often large gaps between pinpoints, e.g., begins to run (20 months) and runs without falling (21 months). Informal measurements can enhance understanding of the child's skills. See Activity 3.

ACTIVITY 2 DEVELOPMENTAL PROGRAMMING

BACKGROUND

Developmental programs for children with handicaps identify the child's status on a developmental continuum (checklist) and provide experiences that permit the child to exercise emerging abilities that in most cases the child will be strongly motivated to use. Developmental assessments help the teacher answer the following questions:

* What skills has the child learned?
* What skills does the child need to learn?
* Is the current instructional program effective?

Answers to these kinds of questions enable the teacher to appropriately alter programs, move on the new instructional objectives, or to continue with the current program.

OBJECTIVES

1. To understand how developmental assessment can be used for programming activities.
2. To practice using assessment information to develop a child's program.

TIME ALLOWANCE

30-40 minutes

MATERIALS

Handout #15: Case study description from Activity 1
Handout #16: Sample Program form

PROCEDURES

1. Do Activity 1. Distribute Sample Program forms to each participant.
2. Using the results of Steven's developmental assessment, plan a sample program for Steven. Develop a behavioral objective for each developmental domain and discuss the activities and methods for reaching the behavioral objective.
3. The trainer may also want to discuss record-keeping procedures and evaluation of the behavioral objectives, e.g., ongoing use of a developmental checklist.

ACTIVITY 3 INFORMAL ASSESSMENT OF CHILD BEHAVIORS

BACKGROUND

Informal assessment techniques can enhance understanding of a child's behaviors. Three basic techniques are:

1. Anecdotal records: narratives and reports of informal observations of the child, e.g., general behavior before and after medication has been changed.
2. Measurements of behaviors: this includes (a) frequency, e.g., how many times a child is out of their seat; (b) duration, e.g., length of time child spends in free time alone; (c) rate: frequency divided by duration; (d) time sampling, e.g., during a ten minute segment of free play, observe child's activity every 60 seconds and record, thus forming a "sample" of behavior.
3. Innovative observation methods: useful tools or tricks that provide necessary child information, e.g., to measure a child's gait, have a group of children paint their feet with white tempera paint and then walk on black paper to form a foot path. The result is a permanent record of the child's gait.

OBJECTIVES

1. To become familiar with informal assessment/observation techniques.
2. To practice using an informal assessment technique that can be used to measure social integration of children with handicaps.

TIME ALLOWANCE

Approximately 30 minutes

MATERIALS

Stopwatch or clock with second hand
Handout #17: Categories of Social Behavior
Handout #18: Social Behavior Observation Form
Toys for role-play

PROCEDURES

1. Review objectives of activity. Distribute handout and discuss social behaviors described.
2. General directions: In order to practice doing an informal assessment, we need three members of the group to volunteer to role-play a free-play situation. (Direct volunteers to

ACTIVITY 3 (continued)

role-play area with toys). The role-players are to pretend they are preschoolers and are engaged in a free-play situation. Participants are going to observe the social behavior of one of the role-players. (Designate a target role-player; this person will spend part of the time alone in unoccupied behavior, solitary independent play and in some parallel play activity).

3. Distribute Social Behavior Observaton Form to each participant and describe use (Trainer should become familiar with the form and its use.)
4. Allow participants to review handouts before beginning activity.
5. Prepare for 10 minute observation segment. Have role-players start engaging in a free-play situation. Trainer reviews procedure for participants: For every minute, observe first 10 seconds; record (tally); observe last 10 seconds; record. Trainer provides cues as to when to observe and record. Start activity and continue for 10 minutes.
6. Have participantscalculate percentages.
7. Compare results of group. Discuss activity.
8. Follow-up discussion: Focus on use of informal assessment in integrating children with handicaps.

ACTIVITY 4 SEQUENCING PUZZLES

BACKGROUND

An assortment of puzzles can usually be found in day care centers and preschool classrooms. Certain puzzles require more skill to complete than others. Knowing the skills needed to put different puzzles together will make it easier to provide puzzles that match the skills of the child so that play is challenging and fun!

OBJECTIVES

1. To become more aware of the skills needed to put together different kinds of puzzles.
2. To be able to sequence puzzles with different levels of difficulty.

TIME ALLOWANCE

15 minutes

MATERIALS

Variety of puzzles with different levels of difficulty

- large knobs
- small knobs
- non-interlocking
- interlocking
- many pieces

PROCEDURE

1. Scatter puzzle pieces in the area of the activity.
2. Pass around each puzzle board and have each participant add a puzzle piece until all of the puzzles are complete.
3. Have trainees sequence the puzzles in order of difficulty.
4. Discuss the skills needed to put each puzzle together and reasons for sequencing them as they did.

ADDITIONAL ACTIVITIES

1. Have a willing friend or participant bring their young child to class and demonstrate some assessment techniques. The Denver Developmental Screening Test has a simple format for this kind of activity that is not difficult to learn or demonstrate.

2. Brainstorm about important influences on child development with the group. Review the list and highlight those influences that they have some control over, including the physical environment, their interactions with the child, the way they structure peer activities, etc. Discuss ways in which they can have the greatest possible impact on children's development in their class or center.

3. List objects and toys that are frequently found in centers. Describe 2-3 ways each item can be used as a "learning tool."

   How can the toy enhance certain concepts? How can it be used to stimulate language development? How can a toy be used to increase social interaction?

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VII. SELF HELP SKILLS & BUILDING INDEPENDENCE

> A young child with a handicap can be free to explore the world once we have unlocked the door to independence.
>
> P. Donsbach

Self-help skills are among the most important behaviors for children with handicaps to learn. These include dressing, toileting, eating, bathing, and management of independent activities.

As children learn more on their own, they will feel better about themselves and will increase their opportunities for learning.

Using the developmental model, teachers and child care workers can program for each child step by step. By gearing the teaching demands to what you know the child can do, you naturally allow for continual success. Each step requires the child to do just slightly more than the one before.

ACTIVITY 1   SEQUENCING SELF-HELP SKILLS

BACKGROUND

This activity gives the participants the opportunity to sequence self-help skills in five different areas: feeding, toileting, dressing, bathing and management of independent activities.

OBJECTIVES

1. To familiarize participants with self-help skills.
2. To give the participants the opportunity to sequence the individual tasks in each area of self-help skills.

TIME ALLOWANCE

35 minutes

MATERIALS

Handout #19: Self-help sequencing sheets
Scissors

PROCEDURE

1. Divide the participants into 5 groups.
2. Give each group a set of tasks under each skill area, feeding, etc.
3. Direct the groups to sequence the tasks.
4. Direct each group to report on their ordering of the self-help skills. Correct the ordering when necessary.
5. Refer to the trainers key for the correct ordering of the tasks within each skill area.

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ACTIVITY 1 (Trainer's Key)
TOILETING, WASHING, GROOMING KEY

AGE	ITEM
18 mo. (12-24)	Indicates wet or soiled pants
	Sits on potty or toilet without resistance
	Is usually dry after naps
	Beginning to signal toilet needs by word or gesture
	Cooperates in washing and drying hands
2.5 yr.	Toilet trained for bowel control (daytime)
2.6 yr. (2.0-3.0)	Pulls pants down for toileting
	Washes hands and face using soap, with assistance
	Dries hands and face after washing
	Knows which faucet is hot and cold
2.7 yr. (2.2F, 2.11M)	Toilet trained for bladder control
2.11 yr. (2.8F, 3.2M)	Goes to toilet without help
3.1 yr (2.8F, 3.5M)	Stays dry all night
3.6 yr. (3.0-4.0)	Removes clothing for toileting (need not buckle, zip or button)
	Has no more than one toilet accident per month (includes waking and sleeping, both bladder and bowels)
	Turns faucets on and off
	Washes face without assistance
	Brushes teeth with assistance
	Wipes nose, when requested to do so
4.6 yr. (4.0-5.0)	Completely cares for self at toilet, including cleansing and dressing. Goes to toilet by self during the night
	Adjusts water temperature
	Washes face well (except for ears) and dries without help
	Brushes teeth without assistance
	Wipes nose without verbal cue
6 yr. (5.7-6.6)	Can brush or comb hair acceptably except for special occasions

F - Female
M - Male

ACTIVITY 1 (Trainer's Key)
MANAGES INDEPENDENT ROUTINES KEY

AGE	ITEM
7-12 mo.	Goes about house without needing to be watched constantly; may need occasional checking as to where he is, what he is doing
13-18 mo.	When told, brings something from or takes something to someplace; is able to find the object from spoken instructions and carries out such orders as "bring it here" or "take it to mommy"
1.6-2.0 yr.	Knows difference between foods and things that cannot be eaten; may put something other than food in his mouth but does not chew and swallow it
2.0-2.6 yr.	Understands and stays away from common dangers; may take care not to fall on stairs or from high places or may show that he knows danger of things, such as broken glass, busy street, strange animals
3.0-4.0 yr.	Carries water without spilling while walking
2.0-4.0 yr.	Carries a tray
3.0-4.0 yr.	Carries breakable objects
3.0-4.0 yr.	Makes effort to keep surroundings tidy
3.0-4.0 yr.	Helps at household tasks (dusting, drying dishes)
3.0-4.0 yr.	Helps with adult activities in house and garden
3.0 yr.	Helps adult, putting his own toys away
3.1-3.6 yr.	Able to keep "working" for at least 20 minutes with similar aged child in a single task, such as making buildings or roads with blocks, logs, sand, or mud, or rearranging a room or area for doll play, such as store, school, or house
4.0 yr.	Fixes a bowl of dry cereal for himself; includes getting bowl and cereal, pouring both cereal and milk into bowl
4.0 yr.	Puts toys away neatly when asked to do so; often must be asked more than once
5.0-6.0 yr.	Puts toys away neatly in box
5.0 yr.	Able to fix a sandwich; must be able to get the right foods from refrigerator, cabinet, and/or breadbox and put them together in a sandwich
5.0-6.0 yr.	Performs simple errands
6.0 yr.	Often does household chores which do not need redoing by an adult (may do them in response to request)

ACTIVITY 1 (Trainer's Key)
FEEDING KEY

AGE	ITEM
3 mo.	Sucking and swallowing are present
7 mo.	Feeds self cracker
9 mo.	Chews table foods
10 mo.	Picks up spoon by handle
10 mo. (7-12)	Lifts a cup to mouth and drinks with some help
12 mo.	Discards bottle
12 mo.	Controls drooling
15 mo. (12-18)	Lifts cup to mouth and drinks unassisted
16 mo. (13-18)	Feeds self with spoon (with some spilling)
22 mo. (19-24)	Discriminates edible substances from inedible ones
22 mo. (20-24)	Uses fork but may prefer spoon
2.4 yr. (2.1-2.6)	Feeds self using a fork and/or spoon and glass correctly
2.6 yr.	Gets a drink unassisted from fountain or sink
2.6 yr.	Sucks from a plastic straw
2.4 yr. (2.1 F, 2.7 M)	Unbuttons one or more buttons
2.10 yr. (2.7-3.0)	Puts on own coat without assistance (need not be buttoned)
2.10 yr. (2.7-3.0)	Puts on own shoes (not necessarily on correct feet)
3.3 yr.	Pours a drink
3.11 yr. (3.9-5.0)	Uses table knife for spreading
4.6 yr. (4.0-5.0)	Uses napkins
4.6 yr. (4.0-5.0)	Fixes bowl of dry cereal (gets bowl, cereal and milk and pours cereal and milk into bowl)
5.6 yr. (5.0-6.0)	Prepares a sandwich including getting food and putting it together
5.6 yr.	Uses knife for cutting

ACTIVITY 1 (Trainer's Key)
DRESSING KEY

AGE	ITEM
3 mos.	Pulls at clothing with hands
10 mo. (7-12)	Assists with dressing by holding out arms for sleeves or foot for shoes
10 mo.	Pulls off hat
12 mo. (10F, 14M)	Pulls off socks
14 mo.	Tries to put on shoes
16 mo. (13-18)	Removes shoes (may be untied)
22 mo. (19-24)	Removes coat without help when button and zippers are undone
3.5 yr. (3.OF, o.9M)	Buttons one or more buttons
3.6 yr. (3.0-4.0)	Can take off all clothing including pull-over
3.6 yr. (3.0-4.0)	Puts on shirt
3.6 yr. (3.0-4.0)	Puts on dress
3.6 yr. (3.0-4.0)	Unzips separating front zipper
3.10 yr. (3.5F, 4.2M)	Puts on boots
4.0 yr. (3.7F, 4.5M)	Puts shoes on correct feet
4.6 yr. (4.0-5.0)	Puts on socks
4.6 yr. (4.0-5.0)	Puts on "pull-up" garments
4.6 yr. (4.0-5.0)	Puts on "pull-over" garments
4.6 yr. (4.0-5.0)	Inserts belt in loops
4.6 yr. (4.0-5.0)	Buttons medium sized buttons
4.6 yr. (4.0-5.0)	Zips front non-separating zipper
4.6 yr. (4.0-5.0)	Zips front separating zipper
4.6 yr. (4.0-5.0)	Buckles belt and shoes
4.6 yr. (4.0-5.0)	Laces shoes
4.6 yr. (4.0-5.0)	Knows front and back of clothing
4.6 yr. (4.0-5.0)	Dresses and undresses unassisted (tying shoes not included)
5.6 yr.	Ties shoelaces

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ACTIVITY 2 WHAT AND HOW TO TEACH SELF-HELP SKILLS

BACKGROUND
This is a review lesson

OBJECTIVES
1. To familiarize participants with how to select the appropriate self-help task to teach.
2. To familiarize participants with methods to use in teaching self-help skills.

TIME ALLOWANCE
15-20 minutes

MATERIALS
Chalkboard/chalk or
Overhead/markers or
Flip chart/markers

PROCEDURE
1. Prepare chart or overhead as follows:

   WHICH TASK DO YOU WANT TO TEACH?
   1. Observe the child for one full day.
   2. Record what the child can do and what teachers have to do for him/her. Put an asterisk (*) next to the ones that you would like to teach the child.

   WHICH SKILL IS THE CHILD READY TO LEARN?
   When choosing a skill, keep in mind:
   1. Some skills naturally precede others.
   2. What the child can already do and what the child might be ready to learn next.

   HOW DO YOU TEACH IT?
   1. Same time each day.
   2. In the natural learning environment.
   3. Using positive reinforcement.
2. While viewing the chart or overhead, review the component listed.
3. Begin a discussion of these principles as well as practical applications of their use. Encourage the participants to talk about actual experiences in teaching self-help skills to their own children or the children that attend their center.
4. Flip to second chart (below) and ask the participants to indicate which task they would choose to teach having observed the following interactions:

TEACHER DOES	CHILD DOES
a. Puts on coat	a. Child looks at teacher, holds arms out
b. Puts on pants	b. Child sits facing teacher
c. Puts on shoes	c. Child does nothing

5. Ask the participants to tell what they chose to teach and why.

ACTIVITY 3 EXPERIENCING EATING WITH VARIOUS MOTOR PROBLEMS

BACKGROUND

Children with motor problems (like muscular dystrophy or cerebral palsy) oftentimes have difficulties during mealtimes. It is imperative that a teacher or caretaker understand the problems that children experience while eating so that they can feed or position them more effectively.

OBJECTIVES

1. To gain empathy about the problems that children with motor impairments experience while eating.
2. To gain understanding of the normal patterns of eating.
3. To provide experience in feeding people with motor impairments.

TIME ALLOWANCE

30 minutes

MATERIALS

Handout #20: Feeding Analysis Grid
Applesauce, spoons, cups, water, cookies and raisins
Handout #21: Feeding Reminder

PROCEDURE

1. Distribute the grid to each participant or pair.
2. Have each person do each of the items on the grid, recording their analysis and feelings. You may refer to the glossary of terminology for help.
3. Upon completion, discuss feelings and implications for programming with the group.
4. Distribute Feeding Reminders (Handout #21).

ACTIVITY 4 PROBLEMS IN MUSCLE CONTROL*

BACKGROUND

In order to be able to develop activities that increase motor independence, it is necessary to gain an understanding of how it feels to have motor problems.

OBJECTIVES

1. To experience the feeling people with physical disabilities have when attempting a task.
2. To increase understanding of how distracting and difficult it is to have a motor problem.
3. To increase awareness of how to position children with physical disabilities.

TIME ALLOWANCE

25 minutes

MATERIALS

Blanket
Towels
(chair with uneven leg lengths)
Story book
Handout #22 - Positioning Techniques

PROCEDURE

1. Lie down on the floor. Try to get up without using your head.
2. Get tightly wrapped in a blanket. Try to roll over.
3. Have the children sit in a small group while you read a story or carry on a discussion. While they are listening, have them keep dropping their heads loosely. Can they follow what's going on?
4. Sit in a wobbly chair (or some other precarious position that you can devise). After a while, notice how much attention and strength you must spend on keeping your balance.
5. Distribute positioning techniques information and discuss. (Handout #22).

*Source: What's the difference. Reprinted with permission.

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VIII. COMMUNICATION

> Just because I can't speak doesn't mean I don't have a message.
>
> -Anonymous

It is through communication that people are able to exchange ideas and share experiences. Most children are able to communicate through the usual channels of oral speech and writing. For many children, however, one or both of these channels are closed due to motoric impairment, difficulties seeing or hearing, perceptual problems (e.g., eye-hand coordination), cognitive or emotional difficulties, or other specific physical disabilities. For these children, trying to communicate with others through speech or writing can be a frustrating and discouraging experience. It is also difficult for people around them--family, friends and teachers--because they feel helpless knowing that the children have thoughts and feelings they want to express, but cannot.

Finding other ways for such children to convey their knowledge and ideas is of the utmost importance. A variety of techniques and aids are now available to assist children with their communicative capabilities. For the child who is handicapped, the use of communication aids parallels the use of writing and gesturing for the speaking child.

The purposes of the activities presented in this section are: (1) to sensitize others to the difficulties encountered by people who are unable to communicate through oral speech and writing, and (2) to increase awareness and knowledge of currently available communication aids.

ACTIVITY 1 MIRROR WRITING

BACKGROUND
Some people with learning problems have difficulties knowing left and right, up and down. This makes it very hard to learn to read, or to learn spatial relationships.

OBJECTIVES
1. To experience the problems of the perceptually handicapped and other learning disabled children.
2. To experience a frustrating situation.

TIME ALLOWANCE
10-15 minutes

MATERIALS
Mirror for each pair
Handout #23 - Mirror Writing
Blank paper

PROCEDURE
1. The objectives are briefly discussed.
2. The mirror is placed on the table with a sheet of paper perpendicular to it.
3. While in pairs, one person holds the mirror and the other participates in the activity. Roles can be reversed after one person completes the activity.
4. They are each told to "look through the mirror and start tracing the star. Your line must stay between the two lines delineating the star."
5. After the participant attempts this task, s/he is told, "Now try to write these letters and numbers as we dictate them to you: 7-p-z-g-s-b-e-2-q-3-c-d."

Follow-up discussion should focus on the objectives. Some questions which may help are:

a. "How did you feel when your hand seemed out of control?"
b. "How did you feel when you checked your numbers and letters after you had them away from the mirror?"
c. "Could you relate these frustrations to the experience of a child with learning disabilities?

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ACTIVITY 2 BLIND WORKER*

BACKGROUND

Vision is a sense many of us take for granted. In a world tailored for sighted people, a visual impairment can present many difficulties.

OBJECTIVES

1. To experience communicating without visual cues.
2. To experience the feeling of dependency and its negative implications.
3. To emphasize effective teamwork.
4. To increase awareness of the visually impaired and other aspects of being disabled.

TIME ALLOWANCE

45 minutes

MATERIALS

1. Blindfolds for each pair
2. Handout #24 - Application for Employment

PRODECURE

1. The objectives are briefly discussed.
2. Pairs are formed.
3. Participants in each pair identify themselves as the worker or the helper.
4. The worker wears the mask.
5. The handout is distributed.
6. The following instructions are given:
   a. The worker is responsible for filling out the form.
   b. The helper must use only verbal instructions in helping the worker complete the form.
   c. The helper cannot touch either the worker or the form.
7. The process begins and after 15 minutes participants in each dyad switch roles.
8. Follow-up.

The entire group discusses their feelings. Trainers should emphasize the stated objectives, especially the feeling of dependency and the frustration of not being able to communicate effectively.

*Source: Ward, M.H., Arke, R.N., Dahl, H.G., & Wise, H.H. Everybody counts! A workshop manual to increase awareness of handicapped people. Reston, Virginia: The Council for Exceptional Children, 1979. Reprinted with permission.

ACTIVITY 3 TONGUE TIED*

BACKGROUND

For a person who has some form of speech impairment, each attempt at communication can be a frustrating experience for both the speaker and the listener.

OBJECTIVES

1. To increase awareness of different types of speech impairments.
2. To develop an understanding of the frustration experienced by speech and language disabled children.

TIME ALLOWANCE

15 minutes

MATERIALS

Four index cards, with a different paragraph on each:

*Average speaker: A speech handicap is not a laughing matter, as it can be extremely embarrassing to the speaker. Even a mild disorder can cause a misunderstanding.

*Articulation disorder: A thpeech handicap ith not a laughing matta, ath it can be ekthtwemely embawathing to the thpeaka. Evan a mild dithawda can cauthe a mithundathtanding.

*Stuttering: a-a-a-a ssspeech h-h-h-handicap is not a-a-a l-l-laughing m-matter, a-a-a-s it c-c-can be, uh, you know, uh very embaaaarrassing to the-the ssspeaker. Eeeven a m-mild dis-dis-disorder can cause a (cough) mis-mis-mis-misunderstanding.

*Language-impaired: Trouble speech not funny. No laughing thing is. Talk feel, hurt, sad. Not know say words.

PROCEDURE

1. Divide into small groups.
2. Each participant selects an index card with a particular speech impediment: stuttering, articulation, language, average speaker.
3. Each read his paragraph in turn.
4. Follow-up:
   After each paragraph has been read, discussion should relate to both the listener's and speaker's feelings during communication. Emphasis should be on the speaker's frustrations in communication.

*Source: Ward, M.H., Arke, R.N., Dahl, H.G., & Wise, H.H. Everybody counts! A workshop manual to increase awareness of handicapped people. Resont, Virginia: The Council for Exceptional Children, 1979. Reprinted with permission.

ACTIVITY 4 READ THE SIGN!

BACKGROUND

Many people who cannot hear use fingerspelling and sign language to communicate. Fingerspelling involves shaping your hands (fingers) into different forms to make the letters of the alphabet. Then it is possible to spell out every word. Sign language is a shortcut to spelling out each word. There are gestures using hands and arms that stand for words and phrases.

OBEJCTIVES

1. To increase awareness of alternate means of communicating.
2. To give trainees experience in using sign language.

TIME ALLOWANCE

20-30 minutes

MATERIALS

Books that illustrate sign language
Paper or index cards for each small group

PROCEDURE

1. Each group makes up a sentence and writes it down without disclosing it to the other groups.
2. Each group is given a book that illustrates sign language (or sign language cards) and is instructed to translate their sentence into a signed sentence. Each member of the group is to learn the sentence in sign language.
3. Each group takes a turn signing their sentence while the other groups try to translate the sentence by observing the signs.
4. Follow-up discussion should relate to the problems faced by the group members in trying to (1) translate spoken English into signed English, (2) learn the correct signs, and (3) communicate in signed English to others.

ACTIVITY 5   BLISS SYMBOLS*

BACKGROUND

Bliss Symbols is an alternative symbol system for the non-vocal pre-reading child or adult.

OBJECTIVES

To familiarize trainees with an alternative symbol system for communication

TIME ALLOWANCE

Total time requires approximately 30 minutes

MATERIALS

Handout #25 - Bliss Symbols Test
Handout #26 - Article on Bliss Symbols
Handout #27 - Article on Communication Boards

PROCEDURES

1. The Bliss Symbol test is administered with the directions of it's originator, Shirley McNaughton:

> Before we introduce the symbols and discuss them in any great depth, I would like to have you take a short test to demonstrate to yourself the relative ease of learning Bliss Symbols compared to what it might be like to learn English. The test only takes a few minutes and is the best way I know to get a comparison of learning Bliss Symbols vs. what it might be like to learn English.
>
> To try this test, you need only a blank piece of paper and a pencil. Now put the numbers 1 through 12 down the left edge of the paper and the numbers 13 through 24 down the center of the page. You are now ready to take the test.
>
> In this test you will be seeing two sets of symbol representations, along with the English translation of them. One symbol set will be the Spence Symbols and the other will be the Bliss Symbols. The first set of symbols has

---

*Source: McNaughton, S. Bliss Symbols - An alternative symbol system for the non-vocal pre-reading child. In G.C. Vanderheiden & K. Grilley (Eds.) Non-vocal Communication Aids For The Severely Physically Handicapped, Baltimore: University Park Press, 1977. Reprinted with Permission.

been designed by Murray Spence, Assistant Co-ordinator, Special Education Programmes, North York Board of Education, in Ontario, Canada. He uses them to provide teachers of early reading programs with the experience of relating to a new medium and attempting to derive meaning from it. Each symbol represents a letter of the English alphabet; the symbols are sequenced to form words on the basis of the sound(s) each symbol represents. The relationship between each symbol and sound is as consistent as English letter-sound relationships!

The second set of symbols are Bliss Symbols with the component parts representing meaning, either directly through a pictorial symbol, or indirectly through an arbitrary or abstract symbol.

Procedure for the test is as follows:

1. Study the Bliss Symbols for one minute, without taking notes. Look for shape-meaning correspondence.
2. Turn to the Spence Symbols and study them for one minute, without taking notes. Look for sound-shape correspondence.
3. Engage in a new and completely different activity for 10 minutes.
4. Return to the test page. Allow yourself one minute; write as many words as you can, doing the easiest ones first.
5. Tally your score from the answer given by the instructor.

2. After tallying score, discuss with the group the questions listed on the answer page.
3. Hand out the article on Bliss Symbols. Review major points of article.
4. Hand out the article on Communication Boards. The trainer should be familiar with the contents of the articles. Make the point that Bliss Symbols is one form of a symbol system that is used on communication boards.

SYMBOLS & COMMUNICATION
(TRAINER'S KEY)

ANSWERS

1. lady
2. little
3. hello
4. happy
5. man
6. sad
7. home
8. afraid
9. mother
10. animal
11. big
12. father
13. happy
14. hello
15. man
16. big
17. animal
18. sad
19. father
20. afraid
21. lady
22. house
23. little
24. mother

When you have completed the test consider the following:

Which symbols did you want to translate first?
Which symbols were easier to retain?
Which symbols appeared visually simpler?
Which required the least effort to analyze?
Which symbols made you think about meaning?

If your score was over 3 for the Spence Symbols, you did better than the majority of workshop attendants to whom I have given this test. If your score was under 9 for Bliss Symbols, you did more poorly than the majority of those trying this test.

Compare your experience in processing the Spence Symbols to that of the young child learning to read. (Keep in mind that the comparison is not entirely valid. The young child brings much knowledge of English letter shapes to his learning-to-read experience. He reads street signs, cereal boxes, people's names, etc., long before his formal reading instruction begins. You, too, however, bring experience of another kind to the task of reading Spence Symbols).

Allowing that the two situations differ in some ways, I hope that the contrast, for you, between learning Spence Symbols and learning Bliss Symbols provides you with an appreciation of the contrast, for the young child, between learning English words and learning Bliss Symbols.

ADDITIONAL ACTIVITIES

1. List general developmental milestones for the acquisition of language and have participants put them in the correct developmental sequence.

2. Display and discuss various alternatives for communication, such as a communication board, an autocom, and various sign language systems.

3. Emphasize the difficulties encountered by persons who are only allowed a yes/no response system by playing the "Twenty Questions" game. The nonvocal player creates a message and the person trying to discover the message must do so through yes/no questions. Discuss the difficulties with such a limited communication system for both the message sender and the receiver.

REFERENCES AND RESOURCES

Vanderheiden, G.C., & Grilley, K. (Eds.), Non-vocal communication aids for the severely physically handicapped Baltimore: University Park Press, 1977.

Dale, P.S. Language Development, New York: Holt, Rinehart and Winston, 1976.

IX. ACCESSIBLE CENTERS

> The motivation to interact with the environment exists in all children as an intrinsic property of life, but the quality of the interactions is dependent upon the possiblities for engagement that the environment provides.
>
> - Anita R. Olds

Is your center easy to enter and move around in? Are objects of daily use, such as bathrooms, coat hooks and toys capable of being reached by all children in the classroom? Environmental barriers are conditions that make buildings, equipment or objects inaccessible. A handicap occurs when obstacles are imposed on a person that put them at a disadvantage.

Barriers to accessiblity include obstacles in the physical environment and other barriers that are less obvious, such as those imposed by disabilities that affect the sense: vision, hearing, touch. Inaccessible environments can also mean inaccessible learning experiences when barriers reduce the opportunities for children to fully participate.

The purpose of this section is to find out what it means to have an accessible center, one that is barrier-free to children with handicaps.

ACTIVITY 1 BARRIERS CHECKLIST

BACKGROUND

An environment that limits usage by persons solely due to their disabilities does not allow those persons to fully develop their potential. It becomes a statement of society's view of the person in terms of the person's disability, not as persons who have disabilities. What kind of statement is your center making?

OBJECTIVES

1. To increase awareness of environmental barriers.
2. To evaluate the accessibility of an environmental setting.
3. To think of ways of making environments more barrier-free.

TIME ALLOWANCE

15 minutes

MATERIALS

Handout #28 - Barriers Checklist

PROCEDURES

1. Have participants complete the Barriers Checklist at their center and bring it to class or have small groups evaluate the accessiblity of the building where the training activity is being conducted.

2. Discuss ways in which each environment could be improved.
    - *What are the things that you think should be changed first?
    - *Are there some things that could be fixed by people using the center, like making signs for rooms, or a ramp for a short flight of stairs?

3. Discuss other buildings that would score better on the Barriers Checklist and how these buildings make it easier for people with disabilities.

ACTIVITY 2 DESIGNING CLASSROOM ENVIRONMENTS

BACKGROUND

Children in the classroom have different needs that may require adaption of the physical environment in order to provide the most effective program. The willingness of the teacher to make these changes is a message to children that each person is important, and efforts will be made to meet each child's needs.

OBJECTIVES

1. To examine ways in which the physical environment can be adapted to respond to the specific needs of children in the classroom.
2. To plan a child care environment with certain criteria in mind.

TIME ALLOWANCE

20-30 minutes

MATERIALS

Flannel board for each group
Packet of labeled (e.g., "chair," "table") felt forms representing room objects
Extra felt and scissors for groups to make additional objects if desired.
Handout #29 - Activity Directions

PROCEDURE

1. Provide each small group with a flannel board, packet of felt forms, extra felt and scissors, and activity directions.
2. Have participants read directions and clarify any questions.
3. Have each group design their classroom environment with the flannel board serving as the floor plan and the felt forms representing objects and furniture in the classroom. Encourage each group to add objects and furniture they feel is necessary based on the children described in the activity directions.
4. After all groups have completed their design, ask a person from each group to describe their group's design, including special additions.
5. The trainer can present other examples of adaptions of the physical environment that take into consideration the needs of people with specific handicaps:

   For hearing-impaired people:
   - use visual clues/signs in classroom, maps of the building, etc.
   - seat child to face speaker(s), the teacher, and other children.

For hearing-impaired people, continued

- write on board or on paper directions for activities.
- use materials and surfaces that transmit sound or vibration so children can be aware of movement and sounds.

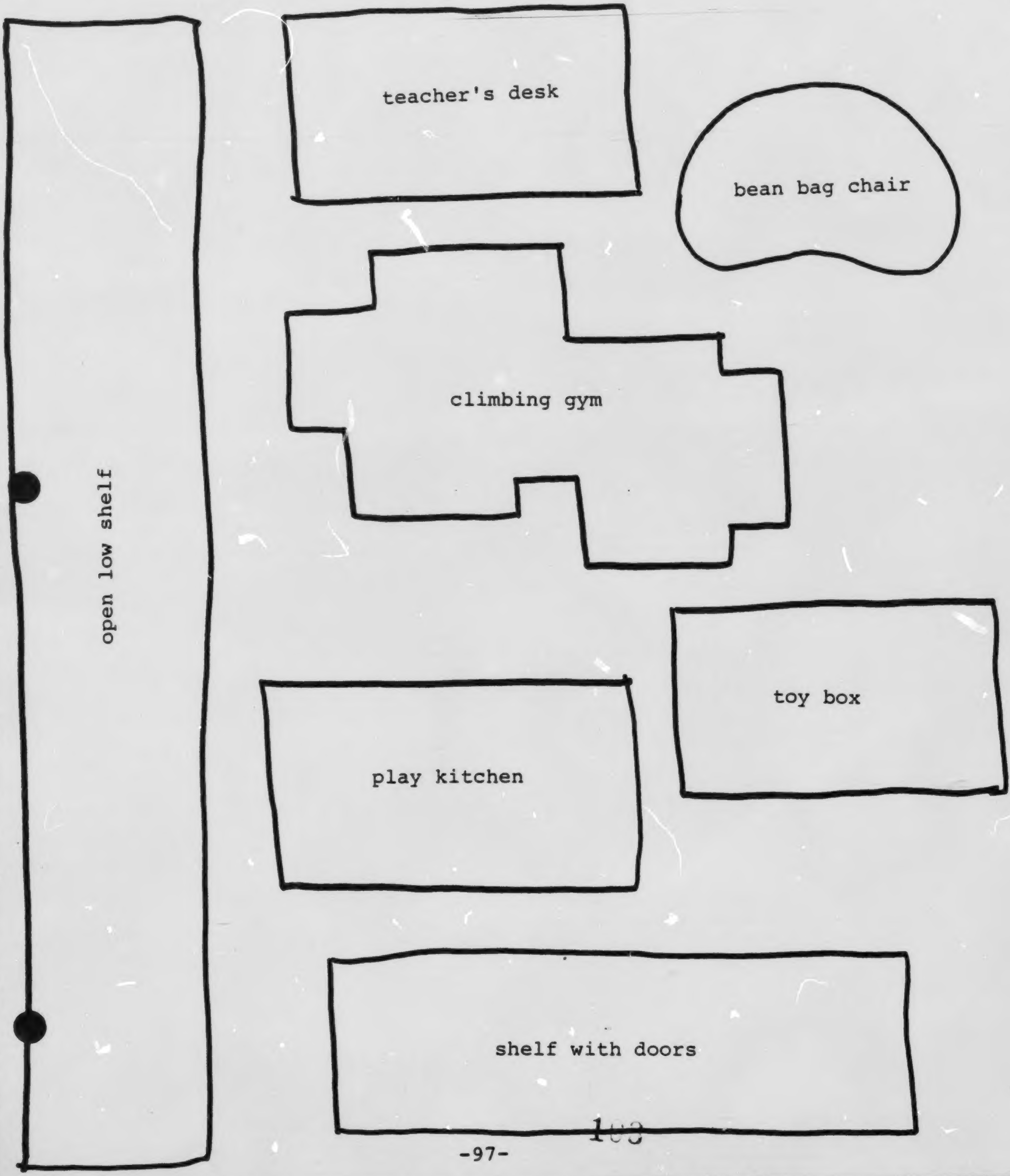
For visually impaired people:

- maintain consistent room arrangement.
- remove barriers so that walking is easy.
- have Braille labels on materials.
- use auditory cues.
- seat near the board.
- have a tape record lessons.

For physically handicapped people:

- have open spaces for wheelchairs and crutches.
- keep activities on one level of building.
- have exercise facilities, like chin-up bars.

ACTIVITY 2 DESIGNING CLASSROOM ENVIRONMENTS: FELT FORMS


open low shelf
teacher's desk
bean bag chair
climbing gym
toy box
play kitchen
shelf with doors

DESIGNING CLASSROOM ENVIRONMENTS: FELT FORMS

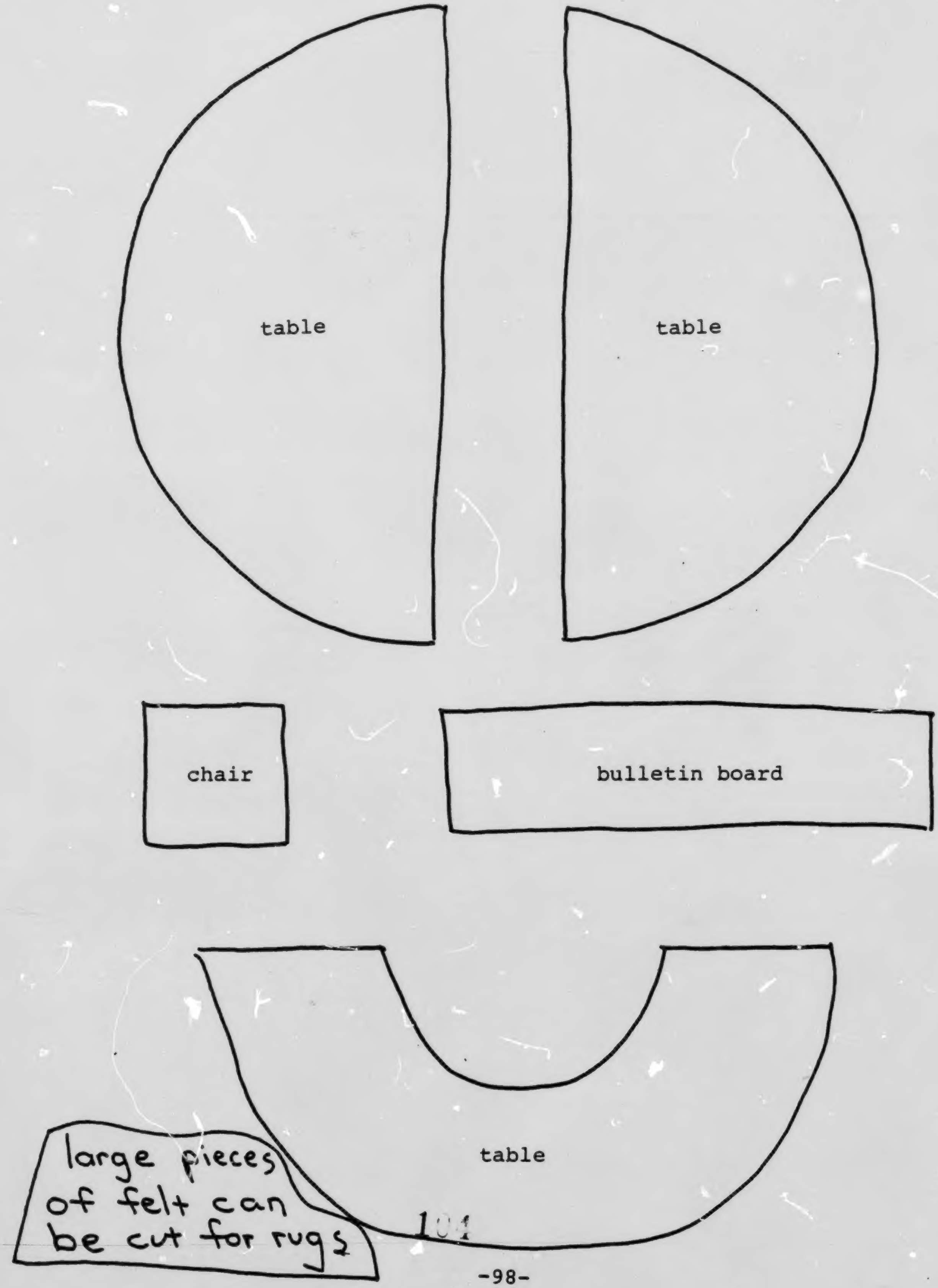


table
table
chair
bulletin board
table

large pieces of felt can be cut for rugs

ACTIVITY 3 OBSTACLE COURSE

BACKGROUND

Creative adaptions that take into account the individual differences of all children will provide more positive and meaningful learning experiences. An obstacle course can be set up that allows each child to participate.

OBJECTIVES

1. To problem solve ways to adapt a structured classroom activity for children with handicaps.
2. To understand how activities of an obstacle course can be used for developmental learning experiences.

TIME ALLOWANCE

15-20 minutes

MATERIALS

Chalkboard or large paper to record adaptions and domains
Handout #30 - Obstacle Course
Optional: Flannel board and felt objects that form the obstacle course can be made and used as a visual aid.

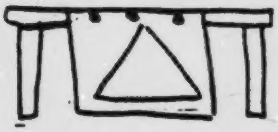
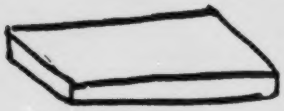
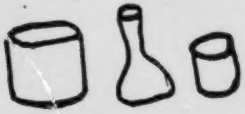
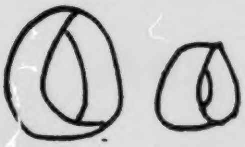
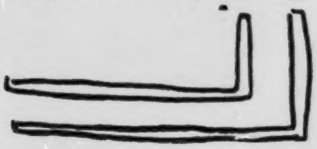
PROCEDURES

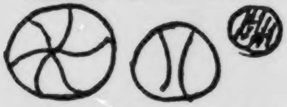
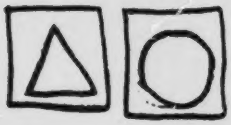
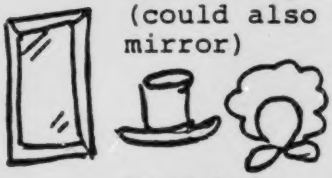
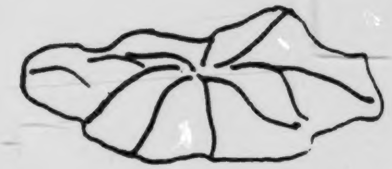
1. Distribute Obstacle Course Handout and give the following directions:

   > Imagine you are designing an obstacle course and you have in mind the Objects/Activities listed in Column 2 on the handout. Your task is to think of at least three ways of using/adapting the Objects/Activities that will allow children with different abilities and skill levels to participate. You are also to determine what developmental domain is tapped by each activity of the obstacle course cognitive, language, motor, social).

   Trainers should be familiar with the Key in order to better understand the intent of the activity. An example would also be helpful for the trainees and may stimulate discussion.
2. Discuss each Object/Activity and record Action Adaptions and Developmental Domains on the board. The trainer can also address specific disabilities and ask for adaptions that would allow a child with the disability to participate.

OBSTACLE COURSE: KEY
Activity 3

Developmental	Object/Activity	Examples of Action Adaptions
Cognitive Motor	Cut out shape hanging from a table 	Go through Go around Go through, around with help
Cognitive Motor Language	Footprint path 	Follow feet Follow & count feet Follow & label left/right
Motor	Mat 	Hop, summersault Roll with help Crawl
Cognitive Motor	Containers & objects to put in containers 	Large container & clothespins Medium container & blocks Bottle & beans
Cognitive Motor	Hoops 	Go through Go around Go in & out
Cognitive Motor	Masking tape path 	Follow path Hop down path Skip down path

Developmental	Object/Activity	examples of Action Adaptions
Cognitive Motor Language	Different balls to indicate Choice 	Look at choice Point to choice Say "red one"; "big one"
	Play with balls	Catch, bounce Roll Hold and feel texture
Cognitive Motor	Large shapes 	Go in & look out Go around and look in Hide inside
Cognitive Motor	Inner tubes 	Go in, around Bounce on Feel textures
Cognitive Social Motor	Dramatic play items (could also add a mirror) 	Show what someone wearing a hat would do Put hat(s) on & off Put hat(s) on & off with help
Cognitive Social Motor	Parachute 	Wait for others under it and then end with a activity, e.g. lifting it up and down

ACTIVITY 4 ADAPTIVE EQUIPMENT

BACKGROUND

Relatively easy constructions of useful objects and modifications to commercial toys can give children with handicaps the access, learning and enjoyment other youngsters experience.

OBJECTIVES

1. To become more aware of the limitations imposed by handicaps that do not allow children to grasp, turn, pull or otherwise participate in their environment.
2. To gain useful ideas about how to construct and adapt equipment.

TIME ALLOWANCE

15-20 minutes

MATERIALS

Handout #31 - Easily Constructed Adaptive and Assistive Equipment
Examples of adapted or easily constructed objects and toys

PROCEDURES

1. Hand out copies of the article "Easily Constructed Adaptive and Assistive Equipment."
2. Discuss the purpose, construction, and use of the equipment described in the article.
3. Show examples of constructed and adapted equipment, including play materials.
4. Ask participants to share their experiences in constructing or modifying equipment.

ADDITIONAL ACTIVITIES

1. Identify environmental barriers that have to be overcome in the course of a typical day for someone in a wheelchair.

2. Have participants draw a floor plan of their IDEAL center and describe. To facilitate this activity, trainer can send for copies of the Early Childhood Planning Guide available from Childcraft Education Corporation, 20 Kilmer Road, Edison, NJ 08817. The guide includes a recommended checklist of materials for child development programs for infants through six year olds. The guide also includes scale cutouts of basic equipment and graph paper for visual planning.

3. Set up an "Adaptive Equipment Workshop". Collect designs for making and adapting objects and toys. Collect or purchase necessary materials and make or adapt equipment during the workshop. You may want to enlist the expertise of local service agencies or individuals.

4. Invite a speaker from the community to discuss mobility techniques that are used by handicapped people.

REFERENCES AND RESOURCES

Dubose, R.H., & Deni, K. Easily constructed adaptive and assistive equipment, Teaching Exceptional Children, Spring, 1980, 116-123.

Olds, A.R. Designing developmentally optimal classrooms for children with special needs. In S.J. Meisels (Ed), Special Education and Development. Baltimore: University Park Press, 1979.

Weber, L. Adapting classrooms for all children. In S.J. Meisels (Ed), Special Education And Development. Baltimore: University Park Press, 1979.

INFORMATION PACKET
Center for Instructional Development, Syracuse University. Barrier-free Designs for The Elderly and The Disabled. Syracuse, NY 13210.

X. WHAT'S IN A FILE FOLDER?

> Organizing is what you do before you do something, so that when you do it, it's not all mixed up.
>
> Christopher Robin

It is important to keep a file folder with pertinent information on each of the children in the center. For children with handicapping conditions, it may be necessary to collect more information on the child to increase understanding about the child's needs in order to program more effectively.

There are several ways to collect additional information as well as methods to interpret it. These will become clear through the following activities.

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ACTIVITY 1 WHAT DO YOU NEED IN YOUR FILES

BACKGROUND

This activity will help the participants determine what information is needed in a child's file folder and how to get it.

OBJECTIVES

1. To understand what sorts of information about the child may be needed in a file folder.
2. To learn how one goes about obtaining information, about a child from other sources.

TIME ALLOWANCE

10 minutes

MATERIALS

Chalkboard/chalk or
Overhead/markers or
Flip chart/markers

PROCEDURE

1. As a group, brainstorm what might be needed in the file folder.
2. Make sure the list has these items included:
   Registration form
   Doctors Reports
   Therapists Reports
   School Reports
   Consent for obtaining records
   Accident Report

ACTIVITY 2 WHAT TO DO WITH THE INFORMATION

BACKGROUND

It is helpful to find out as much as possible about a child with special needs. The information from other special programs, day care center, and parents of the children can be an asset when designing programming. It is important to keep these records updated and complete.

OBJECTIVES

1. To become familiar with the contents of a sample file folder.
2. To identify information that is the most useful in programming planning.

TIME ALLOWANCE

35 minutes

MATERIALS

Sample file folder (included on following pages)
Paper
Pencil

PROCEDURE

1. Pass out the sample file folder contents (duplicate 1 per group of 4 students)
2. Direct the participants to read the folders.
3. As the participants read the information, have them note information on a form like this:

Pertinent Information	How it might be used	Questions for person who wrote the reports
1.		
2.		
3.		
4.		
5.		

4. After the participants have completed this exercise, discuss it with them. (You might want to have a medical dictionary handy).

FILE FOLDER CONTENTS

These forms and reports are samples. They can show participants the kinds of documents and information that might be of use to them in serving a child with special needs. They may be the center or program's own forms or can be copies of reports requested from parents or other agencies (with the permission of the parents.)

SIMULATED FILE FOLDER - General Applicaton for Admission

APPLICATION

Date of Application ____________________

Name of Program ____

Child's Name ______________________________ Birthdate ____________________

What does your child like to be called? ____________________ Sex: M ___ F ___

Marital Status: Married ____ Divorced ____ Single ____ Separated ____

Mother's Name ______________________________ Home Phone ____________________

Home Address ____

Where Employed ______________________________ Work Phone ____________________

Work Address ______________________________ Work Hours ____________________

Father's Name ______________________________ Home Phone ____________________

Home Address ____

Where Employed ______________________________ Work Phone ____________________

Work Address ______________________________ Work Hours ____________________

* *

Name of persons authorized to act for parent in an EMERGENCY:

______________________________ ______________________________
Name Address

____________________ ____________________ ____________________
Home Phone Work Phone Relationship to Child

______________________________ ______________________________
Name Address

____________________ ____________________ ____________________
Home Phone Work Phone Relationship to Child

General Application (cont.)

Name of persons other than parent authorized to pick up your child from school.

Name	Address	Phone
Name	Address	Phone

If you are NOT at home, with whom may the bus driver leave your child?

Name	Address	Phone
Name	Address	Phone

* *

Name of Child's Physician ____________________ Clinic ________________

Address ________________________________ Phone ________________

Does your child have any allergies, including asthma and food allergies?

____

____

Is your child taking any medication? If so, for what? Who prescribed it?

For how long? ____

____

Does your child have convulsions? _____ If so, is your child on medication?

_____ Prescribed by whom? ____

Has your child had his/her hearing evaluated? ________________________

By whom? ________________________ When? ________________________

Results ____

Does your child have tubes in his/her ears? _____ When and who put them in?

____

Has there been follow-up by your doctor? ____________________________

General Applicaton (cont.)

Has your child had his/her vision evaluated? ______________________

By whom? ____________________ When? ______________________

Results ____

Has your child had a neurological evaluation, psychological evaluation, or been seen by any other special doctors? ______________________

____

____

Has your child ever been hospitalized? _____ When? ______________

Why? ____

____

Is your child toilet trained? ______________________

* *

Parent Name ____

Child's Name ____________________ Birthdate ______________

I wish to enroll my child(ren): Full Time ______________

Part Time (A.M.) ______________

Part Time (P.M.) ______________

I intend to bring my child to the day care center at ______________ Time

and pick him/her up at ______________ Time

SIMULATED FILE FOLDER - Intake Information (Specific)

NAME ______________________________ DOB __________ AGE __________

ADDRESS ____

____ (zip code)

PARENTS ______________________________ DATE __________________

ADDRESS ______________________________ TELEPHONE ______________

____ (zip code)

EATING

_____ Must be fed - baby or junior foods
_____ Must be fed - table food
_____ (Does) (Does not) hold bottle alone
_____ Drinks from cup or glass (with) (without) assistance
_____ Eats finger foods
_____ Learning to use spoon - needs (much) (little) assistance
_____ Uses spoon well alone
_____ Uses spoon and fork well but not knife
_____ Completely self-sufficient at table
_____ On special diet (explain)
_____ Other (explain)
_____ Has difficulty (swallowing) (chewing)
_____ Uses food to manipulate parents (explain)

TOILETING

_____ Toilet training not yet attempted
_____ Currently working on training
_____ Child indicates need, must be assisted
_____ Needs no assistance but must be reminded
_____ Has accidents (daily) (weekly) (monthly or less) (in strange surroundings) (when upset or excited)
_____ Has accidents only at night (indicate frequency above)
_____ Completely self-sufficient in toileting
_____ Uses toileting, bed wetting, etc., for attention
_____ Other (explain)

MOBILITY

IF CHILD WEARS A PROSTHESIS OF ANY KIND, INDICATE ABILITIES USING IT (U), AND NOT USING (N)

_____ Makes no attempt to move
_____ (Does) (Does not) (Tries to) roll over
_____ Moves about on floor by (rolling) (scooting) (crawling) (other)
_____ Pulls self up to standing
_____ Stands with assistance (hand, chair, etc.)
_____ Stands alone

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_______ Takes at least 2 steps with assistance (hand, chair, etc.)
_______ Walks alone across room or farther
_______ Stumbles frequently or walks into furniture, doors, etc.
_______ Walks alone with poor balance, does not fall
_______ Walks alone at least 100 feet - movements and balance unimpaired
_______ Walks (up) (down) stairs alone or using banister
_______ Crawls or scoots (up) (down) stairs
_______ Other (explain)

COMMUNICATION

_______ Smiles, laughs
_______ Makes random vocalizations
_______ Imitates sounds
_______ Follows simple directions ("Come here," "No," "Look," etc.)
_______ Uses name of familiar objects or persons (ball, Daddy, cookie, etc.)
_______ Talks in 2-3 word sentences
_______ Talks in longer sentences
_______ Relates experiences
_______ Carries on conversation
_______ Uses words but does not understand their meanings
_______ Can speak but refuses to do so
_______ Indicates needs by crying, grunting, etc.
_______ Indicates needs by pointing
_______ Indicates needs by leading parent, etc., to door, refrigerator, etc.
_______ Speech is difficult for family to understand
_______ Speech is difficult for strangers to understand
_______ Speech is understood by strangers after 5-10 minutes
_______ Speech is readily understood by strangers but therapy is recommended (explain)
_______ Speech quality unimpaired
_______ Other (explain)

HEALTH PROBLEMS

_______ None present
_______ Hyperactivity
_______ Frequent upper respiratory infections
_______ Other respiratory ailment (asthma, etc.)
_______ Impaired vision (explain)
_______ Impaired hearing (explain)
_______ Seizures (explain types; frequency; aura, if any; date of onset; cause, if known; complications, even if seizures are now controlled)
_______ Hydrocephalus (arrested? How?)
_______ Heart defect (explain)
_______ Color blindness
_______ Drooling
_______ Menstruation began at age __________
_______ (Does) (Does not) care for self during period
_______ Orthopedic difficulties (explain - is surgery anticipated? when? describe any orthopedic appliances required or recommended. Give approximate dates and types of past orthopedic treatment)
_______ Dental problems (explain)
_______ Allergies (list)
_______ List all serious illnesses (if necessary or recent enough to concern sitter)
_______ Limbs missing

________ Metabolic disorders (explain)
________ Neurological impairment (explain)
________ List all medications currently given or prescribed, including dosages and purposes
________ High tolerance to pain
________ Other (explain)

SOCIALIZATION

________ Reaches for familiar persons
________ Enjoys being held and played with
________ Plays with or along side other children
________ Shies away from strangers
________ Plays cooperatively with other children
________ Deliberately abuses or antagonizes other children (explain - how often?)
________ Refuses to obey parents or others in authority
________ Deliberately abuses self (explain)
________ Prefers company of (older) (younger) children
________ Prefers to be left alone
________ Becomes frustrated when ____
____
________ Handles frustration by ____
____
________ Responds to change in routine by ______________________________
________ Responds to correction by ____________________________________
________ Describe interaction with siblings ____________________________
____

SUPERVISION NEEDED

________ Must be watched constantly
________ Plays (knowingly) (unknowingly) with dangerous objects if not watched (give specifics)
________ Avoids sharp objects
________ Avoids hot stove and pans
________ Goes into street (or would if not watched) without looking for cars
________ Crosses street safely after looking for cars
________ Not allowed to enter street alone - can be trusted to do so
________ Wanders away from home while awake
________ Wanders in sleep (within home) (away from home)
________ Takes supervision from older children in authority
________ Can be left alone in house for 20 minutes
________ Can be trusted to watch younger children for 10 minutes
________ Behavior in public is (better than) (worse than) (same as) at home
________ (Can) (Cannot) be trusted not to take things from store shelves without permission
________ Takes things that don't belongto him (knowing) (not knowing) it is wrong
________ Can be trusted to perform minor errands (mail letters, borrow an egg from neighbors)

PERSONAL SELF-HELP

________ Fears bath
________ Must be bathed
________ Learning to bathe self
________ Bathes alone if water is run for him
________ Runs water and bathes self, doing (good) (fair)(poor) job

_______ Tooth brushing not yet begun
_______ (Does) (Does not) cooperate while teeth are brushed
_______ Learning to brush own teeth
_______ Self-sufficient at toothbrushing (though reminders may be necessary)
_______ Recognizes "well groomed" and "sloppy" on (self) (others)
_______ Combs or brushes hair in (play) (grooming)
_______ (Shampoos) (Sets) hair (alone) (with assistance)
_______ Does not help dress self
_______ Removes coat or dress alone if unfastened
_______ Puts on coat or dress; (does) (does not) fasten it
_______ Operates (zipper), (buttons), (snaps), (indicate which)
_______ Ties shoestrings
_______ Tells time to nearest (hour) (half hour) (quarter hour) (5 minutes)

Has child ever lived away from home?__________ If so, give dates and details.

SIMULATED FILE FOLDER - Release of Information

1)
To: ______________________________
____
____
____

2)
Re: ______________________________
____
____
____

I hereby grant permission to disclose and deliver to:

any and all information contained in the clinical record of the above named patient. Such information disclosed or delivered may include the complete case history as shown by the records, and any other information in the possession of (3) __________________ relation to this child's treatment and/or condition.

(4) SIGNATURE WITNESSED BY:

________________________ (name)

(5) Signed: ________________________

________________________ (address)

Date: ________________________

FOR DOCTOR'S RECORDS

NOTE: INSTRUCTIONS FOR FILLING OUT ABOVE

1. Give full name and address of doctor.
2. Give patient's full name, and birthdate.
3. Give full name of medical office, institution, etc. releasing information.
4. Give full name and address of witness.
5. Signature of parent or guardian of patient and date of signature.

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SIMULATED FILE FOLDER - Day Care Report - Fall

UCP Extended Day Care
December, 1979

D.O.B. 10/6/75

Program

________________ attends the ___________ Day Care Center one full day, four afternoons, and five early mornings per week. He attends the Early Childhood Program four mornings per week at Mendota Elementary School.

___________ arrives every morning about 7:00, and is at the center until 8:30 when a bus comes to take him to Mendota School. ___________ returns by bus to the Salvation Army at 11:45 in time to eat lunch with the other children. Following lunch is nap time. _________ usually sleeps from 1:00 until 3:00. Afternoon snack is at 3:15. The children are then split into two groups, ahlf are in the large motor room, the other half are in the classroom where they have choices of activities to do. __________ alternates between the two rooms during this time.

General

____________ enjoys listening to and watching the other children play. During free play time, if the children are making noise, ________ voice joins right in with theirs. ________ seems to be cooing more on his own. He enjoys having someone coo back to him. Music seems to elicit sounds from ________. He likes to listen to music. ________ also enjoys the large group times. He responds during story time, or when songs are being sung by laughing and talking.

Feeding

_____________ sits on the teacher's lap to be fed. In the past, _____________ sat facing the teacher, his legs straddling the waist. He has grown, and is now too long to be held in this way. _____________ sits across the lap, having his back and head supported by the teacher's arm and hand. __________ is spoon fed. A rubber tipped spoon is used. _______ drinks out of a tippy cup. __________ diet consists of pureed food or baby food. We are working on having __________ chew some soft chopped food. It is important to encourage ________ to drink fluids, as they aid in loosening his congestion.

A chin strap is currently being used with _______ during eating times and nap time. It is used to aid in eating and respiration. It has only been in use for a short period of time, so it is difficult to make any definite conclusions; however, __________ seems to be holding his lips closer together. It is hoped the chin strap will aid in chewing.

_________ eating habits are not consistent. When ________ is feeling well and is in a happy mood, he will eat a good lunch. If ________ is very congested, or just is not feeling well, he will not eat very much. It is difficult during these times to get ___________ to eat more than two or three spoonfulls.

Positioning

A wedge is used with _______ while he is on the floor. The best position to use while he is lying on the wedge is to have him on his stomach. There are two reasons for this position, 1) there is not as much drainage into his throat, and 2) he is able to push his head and upper body up on his forearms to look around. He has been showing much more movement while on his wedge. He seems to be gaining more head control when he lifts himself up on his forearms.

Goals

The major goals for ________ at the center are: 1) encourage him to lift his head by talking and shaking a rattle or similar object above his head, 2) work on grasping objects in his hands, and 3) increase and encourage vocalizations by imitating his sounds.

School/Parent/Center Coordination

There is a good line of communication between the center, school, and parents. __________ has a notebook that is sent from home to the center, to school. it is used to communicate any needs, concerns, or information. Communication is also very good between the staff at Salvation Army and __________ mother.

The resource teacher has visited ________ classroom at _________ school to discuss goals, expectations, and techniques to use with _________ when working with him. ___________ Occupational Therapist at Mendota has visited the Day Care Center to share techniques of feeding and positioning during feeding.

___________ was at Central Wisconsin Center for two weeks this fall for respite care. He was there from November ___ through November ___.

UCP Resource Teacher

Re-evaluation Summary April 80

NAME:

UWH# 764044-4 Age: 4½ yrs.

PRESENT SITUATION:

1. Seizures better - takes phenobarb dilantin, Depakene & Tegretol - also Valium - Followed by Dr. Cheun.
2. More relaxed, responsive & sociable when feeling well
3. School reports some reaching in side lying. Feeding much easier. Gets postural drainage daily
4. Very constipated - discussed use of Ped. Fleet enema.
5. Has been healthy all winter - fantastic!
6. Still using wedge at night.

FINDINGS:

1. Looks good - relaxed & breathing easily. Chest clear No seizures noted. Marked gum hypertrophy. Ears have wax ++ bilaterally. Wgt. 22.5 lb Hgt 37.5
2. ROM well maintained. Present wedge results in good position on the Rt, but int rotation at L hip. XRay hips - 2/3 L femoral head is uncovered. Rt good position. Lies with L hip high. Modified wedge position to encourage flex L knee & abd & ext. rot hip
3. Bathing difficulties - TLC chair tried.
4. Audio - hearing grossly normal. Wax ++ in ears.
5. FBC - Hct 41% : Hgb 13.8 : RBC 4.8 ; WBC 6.7. SGOT 25 : Pheno 20 : Dilantin 8 : Tegretol 1.2 : Depakene 65. (Tegretol is low - rest OK).

RECOMMENDATIONS:

1. Modified wedge to be used to better position hips in abd & ext rotation. Watch position on L
2. Suggest use of Debrox & have ears washed out
3. Use enema for constipation then diet & meds. Call if problems occur.
4. Re-evaluation 6 mths Oct. ~~Aug.~~ 80. (XRay hips AP. ortho. pre bloodwork)

cc: Mo
Dr.
School

Dave G DDB
UCP Day Care
UW Records.

ILE FOLDER - Public School Individual Educational Plan (I.E.P.)

METROPOLITAN SCHOOL DISTRICT: INDIVIDU[illegible]UCATION PROGRAM: 78-79 YEAR

PHASE II: PROGRESS-TO-DATE ANNUAL REVIEW

CA: 3-7

Student Name	Student Number	D.O.B.	Sex	Grade	School
		10-6-75	M	Pre	

1. **Statement of Student's Program:** ______ has been in the Early Childhood progra since age 13 months. For the 78-79 school year, programming has consisted of 2½ hour classroom sessions 4 mornings/week. An EEN teacher was always present for assessing and programming in cognitive and socia play skills, as well as carrying out programming in speech and langu fine and gross motor, and feeding. A physical therapist and an occupational therapist were present 2 mornings/week for assessing, monitoring, and programming in fine motor, gross motor, and feeding.

2. **Description of Regular Education Environment, Expectations, and Alternatives:**

N.A.

3. **Description of Home, Community, and/or SPECIALIZED EDUCATION SERVICES Involvement:** ______ is in contact with the staff on a weekly basis to relay information regarding ______ progress/behavior at home, medical and clinic visi results, and to request handling suggestions and home programming. She has met with the staff 2x this year to review ______ progress and help set programming objectives Staff has been in contact with Cerebral Palsy Clinic staff, CWC respite care staff, and Extended Day Care (______) staff through phone calls, reports, and conferences to review progress

Summary of the Student as a Learner: (To include, but is not limited to, student's present level of educational performance, abilities, achievements, likes/dislikes, other affective, communicative, motor, and cognitive skills...) ______ diagnosis consists of central nervous system damage, severe spastic quadriplegia, microcephaly, seizures, severe mental retardation, and cortical blindness. He is presently functioning at the 4-6 month level in cognitive/sensorimotor skills (3 year delay); approximately 4-6 month level in early communication with scattered skills ranging from 2-8 months (3 year delay); 3 month level in gross motor (3+ delay); 3 month level in fine motor (3+ yr delay). ______ is transported in an orthokinetic wheelchair with bilateral head supports, abduction wedge, and neck foam brace to keep hea in place. He is presently wearing short leg braces.

I.E.P. (cont.)

METROPOLITAN SCHOOL DISTRICT: IEP-PHASE II: Page 2 78-79 YEAR

Student Name	Student Number	Report Period Covering August 78 to June 79	Report Date May 79

Progress-to-date: Evaluation of progress made on each annual goal and objective listed in IEP-Phase I. Include results of testing.

1. Cognition and Early Communication

A. ______ increases activity and vocalizes similar sounds when he hear "own" sounds, both child and adult initiated. When peers vocalize either individually to him or as a group in a nearby activity, responds with own sounds.

B. ______ is beginning to use sounds using velar closure. He is using both increasing ~~and~~ decreasing intonation patterns, his jaw remains still when vocalizing vowels, and he is sustaining vocalizations for 3 seconds. Vowels being used are "a", "oo", "eh".

C. ______ is presently using smiling to show pleasure and intere in speaker or toy; crying for pain, discomfort, and fear; whining when he wants attention (nobody is working with him); and protests by turning his head away from stimulus and stiffening.

D. Action repetition is accomplished through head lifting toward quiet stimuli accompanied by vocalizations and increased body movement (smile, kick).

E. No improvement has been obtained in this area.

F. ______ can grasp an object for up to 5 minutes after it ha been placed in his hand (can occur with simultaneous grasp in both hands). He can shake a rattle or bell durin the grasp.

-6: Refer to Related Services IEP Phase II.

METROPOLITAN SCHOOL DISTRICT: IEP-PHASE II: Page 3 78-79 YEAR

Student Name	Student Number

Recommendations for Following Year: (To include but is not limited to program recommendations, goals and objectives, instructional strategies, types and range of exceptional education and related services...)

1. Program in sensorimotor areas of cognition and early communication
   a. begin searching skills
   b. match similar sounds when stimulus changes
   c. hand transfer
   d. hit and pat objects
   e push objects
   f. vocalize to attain toy.
   g. develop cvc and rapid repetition of bilabials.
2. Continue social interaction with peers and adults.

Additional Comments:

Parent Participation Date(s) ______ Parent Signature 6/4/79 ______ Student (if appropriate) ______

Person(s) completing progress-to-date

Signature ______ Title EEN Teacher ______ Date 5/79

Signature ______ Title ______ Date ______

Signature ______ Title ______ Date ______

April 1978

I.E.P.

ogress-to-date: Evaluation of progress made on each annual goal and objective listed in EP-Phase I. Include results of testing.

±1f Increase length of grasp & improve quality of reaching

See IEP PHASE II p.2 (1). ______ is around the 3 mo level in fine motor skills. Limiting factors are blindness and muscle tone,

Continue Feeding Program

______ is currently wearing a chin strap (since 5/4/7 for about 6 hours a day, including meals, and 3 hours at night. He continues to be fed in a lap, sitting upright with head control given at the top of the head (gentle downwards pressure). Food is presented at midline on a rubber coated spoon. ______ is eating soft chopped foods, crackers, and ground meats. Changes noted since ______ began wearing the chinstrap are:

1) He is using his bottom lip more in a cleaning/sucking manner.
2) He appears to be swallowing more quickly: especially ~~with~~ liquids
3) He is no longer getting the retraction or "away from" response to the spoon in his mouth.
4) He opens his mouth an appropriate amount to receive the spoon
5) He is getting a small amount of upper lip movement in an attempt to clean the spoon
6) He looses more food, but this does not occur at the beginning of a meal (maybe fatigue from use of a slightly different pattern—or the ______ looses interest in the food?)

I.E.P.

METROPOLITAN SCHOOL DISTRICT: IEP-PHASE II: Page 2 78-79 YEAR

Student Name	Student Number	Report Period Covering	Report Date
		9/78 to 5/79	5/25/79

Progress-to-date: Evaluation of progress made on each annual goal and objective listed in IEP-Phase I. Include results of testing.

I have videotaped ______ before the chinstrap and after 1 day with the chinstrap. I will videotape again on the last day of school (5 weeks in chinstrap). By reviewing these tapes it will be easier to see changes, and to make changes in his program.

______ continues to have a severely hyperactive gag reflex. However, he is once again able to handle a spoon and foods such as crackers.

Facilitate respiration

Although lateral pressure and inversion appear to facilitate increased inhalation, there is not carry over (once facilitation is stopped) For this reason we are trying the chinstrap. Although his respiration appears to be deeper, it will be easier to assess after reviewing the tapes. Also baseline measurements have been taken of chest circumference and respiration rate. ____ continues to get postural drainage at home & at school & his coughing during & after drainage seem deeper & more effective. OT & PT

ADDITIONAL ACTIVITIES

1. Create a form for recording such things as significant events, parent contacts, school visits, discussion with social workers, child progress, etc.

2. Have participants bring in samples of their own forms and file folder contents to share with the other participants. This may be a way for the class to create their own forms.

3. Discuss issues related to confidentiality of records. When is confidentiality an asset and when does it get in the way of communication?

XI. MAINSTREAMING: PATHWAY TO NORMALIZATION

> "If you treat an individual as he is, he will stay as he is, but if you treat him as if he were what he ought to be and could be, he will become what he ought to be and should be."
>
> Goethe

The history of setting groups of people off to one side in society and explaining it as being "in their best interest" has been costly. Few of us have grown up in a school with the privilege of knowing a friend who had a physical disability who learned very differently or who had no hearing or sight. Deprivation and lost opportunity to grow are common to people with special needs. Their lost opportunity to grow is ours as well.

Applying the principles of normalization can break this cycle and ensure that people with disabilities are integrated into everyday community life. Mainstreaming children with handicaps in day care and preschool is a major aspect of the normalization process. It is an important first step in establishing a life of equality for all people with handicaps.

ACTIVITY 1 SEPARATION VERSUS BEING PART OF THE MAINSTREAM

BACKGROUND

Historically, people with special needs have been segregated into large institutional settings, into separate educational facilities and classroom, separate recreational programs, and separate work places.

OBJECTIVES

1. To determine who benefits from segregation.
2. To determine the effects of separation.

TIME

20-30 minutes

MATERIALS

Chalkboard/chalk or
Overhead/markers or
Flip chart/markers

PROCEDURE

1. Put the following chart of the board:

	YES	NO	WAYS
The community in general			
The person's family			
The taxpayer			
The particular individual			
The professional			

2. Ask the following questions:
   * Who has benefitted from the segregation of people with special needs? (Check Yes or No)
   * In what ways has the person or group benefitted from the segregation of people with special needs? (List in column)

3. After completing the chart, ask the following questions:
   * What happens when a sufficient stigma is attached to a person so as to dehumanize him/her and then segregate that person so s/he is deprived of the usual experiences of living in society?
   * Is it likely that this increases the dependency of those people who already have special needs?
   * Can you think of other consequences?
   * What can you do about them?

4. Discuss the consequences of segregation and write out some ideas about how to overcome them. Examples:
    - *Writing letters to service providers supporting mainstreaming and normalization
    - *Becoming a citizen advocate to a person with disabilities
    - *Conduct public awareness activities

ACTIVITY 2 ME TOO

BACKGROUND

This activity provides an opportunity for participants to reflect on their own individual differences. It also touches on the issue of "labeling".

OBJECTIVES

1. To develop greater awareness of individual differences.
2. To understand how labeling affects the number of options one has in life.

TIME ALLOWANCE

10-15 minutes

MATERIALS

None

PROCEDURE

1. Have participants share their own "handicaps" or instances when they had "special needs", e.g., broken leg, and needed crutches, anesthesia from dentist that made it difficult to control facial muscles, etc. Note whether these handicaps or special needs were temporary or are permanent conditions. Discuss how these conditions changed aspects of daily living.

2. For homework have the participants note each time a person or group use a label that is not flattering. Beside each phrase or word, have the participant write a more appropriate word.

ACTIVITY 3 EVERYBODY'S RIGHTS!

BACKGROUND

By attaching a negative value to the intellectual limitations of such persons, society has conveyed the message to the person so labeled that s/he is so different from the rest of use that this difference renders him/her a lesser member of society. The perception of the person with special needs as a social inferior has resulted in the building of legal and social barriers to prevent the exercise of many of the rights most of us take for granted.

OBJECTIVES

1. To clarify the importance of individual rights.
2. To consider how the absence of individual rights leads to dehumanization.

MATERIALS

Handout #32: Individual Rights
Paper/pencils

TIME ALLOWANCE

25 minutes

PROCEDURES

1. Distribute Handout #32 to each participant.
2. Have participants read the rights aloud.
3. Ask the participants if they believe in these rights or if they view them as platitudes.
4. Have each participant list 3 rights that they would be willing to sacrifice if they had to cut their list to 10. You have no choice. Give up 3!
5. Now have the participants cut their list to 7. Ask each participant what they would give up.
6. Discussion questions:
    *How many rights can you cross off your list before you begin to feel dehumanized?
    *If people who have disabliities do not have these rights, are they dehumanized?
    *How can you tell?
7. Wrap up the activity by reading or paraphrasing the ideas expressed in the following paragraph:

    > We cannot enjoy the things we hold as precious as life itself - freedom to associate with anyone we wish, to live, and work, and play where we wish and above all to test how much we can learn and grow together--if there is a wall between us and the associate we need to know. If anyone is the prisoner of our poor expectations then we all are. Normalization is the the freedom we all seek.

REFERENCES AND RESOURCES

Biklen, D. Let our children go. Syracuse, New York: Human Policy Press, 1974.

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XII. WHAT'S THE NEXT STEP? INTEGRATIVE ACTIVITIES

> The woods would be very silent if no birds
> sang there, except those who sang best.
>
> James Audubon

Once a center has decided to mainstream and is committed to success through determination, the next step is to develop appropriate activities for the entire group.

One of the best ways to enhance any young child's experiences is by doing sensory activities. When children have difficulties receiving input through one of their senses such as sight, hearing, or touch, it helps to use as many other senses as possible to reach them. This section of ideas will help stimulate teachers to plan activities involving the senses when working in an integrated setting.

ACTIVITY I - HOW TO CREATE YOUR OWN SENSORY ACTIVITY

BACKGROUND

Sensory activities are fun, exciting and stimulating for children. Participants are encouraged to design their own sensory experience to be used with young children.

OBJECTIVES

1. To learn to design activities for children who have sensory impairments.
2. To collect ideas for activities from other class participants.

TIME ALLOWANCE

Homework activity
10-15 minutes for each participant to present their activity.

MATERIALS

Participants are to provide their own materials for their activity.
Handout #32: Sensory Activities for Children

PROCEDURES

1. Participants are given ample out-of-class time to develop an activity.
2. Each participant gives directions and guides the activity.
3. After the activity period, the group discusses which senses were involved and brainstorms possible adaptations.
4. Additional activities can be conducted or copied for them. Handout #32.
5. The trainer might enjoy ending this activity session with "The Gunniwolf Story", which follows this page.

THE GUNNIWOLF STORY

The following story was designed to involve all of the senses. This type of active involvement is a wonderful way to increase a young child's attention span. After you have told the story to children you can increase participation by letting the children do the special sensory effect themselves. This story involves all five senses and is guaranteed to hold a child's attention.

	STORY	Special Sensory Effects
NARRATOR:	Once there was a little girl named __________ who lived right next to the ______________ woods. (name of town) One day her mother said:	
MOM VOICE:	"I am going to the store for a while. Would you like to go along, or would you rather stay home by yourself?"	
CHILD VOICE:	"I think I will stay here and play in the sandbox," said __________.	
MOM VOICE:	Her mother said, "O.K., honey, but be sure you don't wander out near the woods. Remember, we don't want you to meet up with the Gunniwolf."	
CHILD VOICE:	"Don't worry, I will stay right here, Mommy."	
NARRATOR	While her mother was away, __________ sniffed the sweet fragrance of the lovely flowers in her yard while the brisk wind ruffled through her shiny hair. __________ loved the warmth of the sun in early spring. In the distance she could her the birds chanting a lovely melody through the trees and the frogs plopping form lily pad to lily pad in the nearby pond. __________ became so involved with the wonderful day that she aimlessly wandered to the edge of the pine forest. __________ caught sight of some beautiful blue flowers and decided to pick some for her mother. As she bent down to pick one, she sang:	-spray spring flower air freshener -fan gently -pick up blue flowers (plastic or real)
CHILD VOICE	DO MI DO MI SO SO SO	-play these notes on xylophone or piano and sing

NARRATOR:	After she gathered a few blue flowers, she looked through the pines and saw the prettiest pink wildflowers in the whole world. She leaned over to pick several, took a big sniff, and sang:	
CHILD VOICE:	DO MI DO MI SO SO SO	-play and sing
NARRATOR:	Her flowers looked so lovely, but she thought it would be perfect if only she could find some yellow ones. She walked deeper and deeper into the woods and she finally spotted them--gorgeous yellow flowers. She bent down to pick some while singing:	-pick yellow flowers
CHILD VOICE	DO MI DO MI SO SO SO	
NARRATOR:	...and all of a sudden - GROWWWWWL - there was a huge gunniwolf towering over her. The little girl started to run, pit-a-pat, pit-a-pat, but the gunniwolf chased her, hunk-a-chu,and grabbed her and said:	-furry puppet
GUNNIWOLF:	"Little girl, little girl, Why you move?"	-furry puppet
CHILD VOICE:	"I no move."	
GUNNIWOLF:	"Then you sing that good-um sweet-um song."	
CHILD VOICE:	DO MI DO MI SO SO SO	-play and sing
NARRATOR:	As she sang, the gunniwolf fell fast asleep. The little girl ran as fast as she could, pit-a-pat, pit-a-pat, but the gunniwolf woke up and chased her hunk-a-chu, hunk-a-chu, and he grabbed her again and said:	
GUNNIWOLF:	"Little girl, little girl, Why you move?"	
CHILD VOICE:	"I no move."	
GUNNIWOLF:	"Then you sing that good-um, sweet-um song."	

CHILD VOICE: (SHAKILY):	DO MI DO MO SO SO SO	-play and sing
NARRATOR:	And once again the gunniwolf fell fast asleep. This time the little girl gathered up her flowers from the ground and ran, pit-a-pat, pit-a-pat, all the way home. When __________ got home, she flew into her mother's arms and told her of the big gunniwolf.	-furry puppet -snoring noise
MOTHER VOICE:	"Did the gunniwolf hurt you?"	
CHILD VOICE:	"No, Mom."	
MOTHER VOICE:	"Did he try to take your flowers?"	
CHILD VOICE:	"Well, no Mom. You know, I guess he just wanted to hear me sing a little song. Let's invite the gunniwolf to our house to hear some of my songs. Maybe we can even bake some cookies for him."	
NARRATOR:	The next day, the smell of chocolate chip cookies and the little child's sweet song brought the big gunniwolf to the edge of the woods where he was greeted by __________ and her mother. The gunniwolf sat down to listen to the singing and while Mother passed around the cookies, __________ sang:	-cookies
CHILD VOICE:	DO MI DO MI SO SO SO	-play & sing

*This story was adapted for use with children who have handicaps by the Macomb 0-3 Regional Project, Macomb, Illinois.

ACTIVITY II - THERE IS MORE TO MAINSTREAMING THAN MEETS THE EYE

BACKGROUND

The exercises and activities in this manual were designed to influence attitudes as well as provide helpful information to day care and preschool staff who are integrating children with handicaps into their centers. Having a positive attitude and the willingness to attempt mainstreaming is only a start. Once a child with a disability is enrolled in a center, it is imperative to monitor peer involvement to insure positive social interaction.

OBJECTIVES

1. To be able to select play materials that encourage integration of young children.
2. To explore situations which support true socialization through interaction.

TIME ALLOWANCE

20 minutes

MATERIALS

Variety of toys, games, puzzles, manipulatives
Blackboard/chalk

PROCEDURE

1. Discuss the levels of involvement chart/overhead information which is listed below:

LEVELS OF INVOLVEMENT

1.	Segregated	no chance for interaction
2.	Partial Contact	children in same building - together in hallways, lunch, etc.
3.	Integrated	opportunity for social interaction exists
	no interaction	exposure to integration - no socialization
	partial interaction	handicapped child initiates
		typical child initiates
		adult initiates
	total interaction	comfortable involvement

ACTIVITY II - continued

2. Set out play materials and have the participants classify them as individual or group involvement materials. Ask them to list their reasons for their grouping choices.

   e.g. individual materials include small puzzles, playdoh, small manipulatives.

   e.g. group materials include large building blocks, games, dress-up playclothes, puppets, large puzzles, bowling, bean bags.

3. Talk about the effect that the three types of grouping: developmental; chronological, and multi-age, have on the patterns of integration. Relate these grouping patterns to classroom materials and interaction possibilities.

REFERENCES AND RESOURCES

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Engle, Rose. Language motivating experiences for young children. Van Nuys, California: DEA Publishers, 1968. (Order at 6518 Densmore, Van Nuys, California 91406)

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Taylor, B., A child goes forth: a curriculum guide for teachers of preschool children. Provo, Utah: Brigham Young University Press, 1964.

APPENDIX A

COURSE EVALUATION

INTEGRATING THE DEVELOPMENTALLY DISABLED CHILD INTO DAY CARE AND PRESCHOOL

DATE ____________________

LOCATION ____________________

TEACHER(S) ____________________

____

____

Overall the course was: _____Excellent _____Good _____Fair

_____Poor

	Strongly Agree	Agree	Somewhat	Disagree	Strongly Disagree
WORKSHOP CONTENT					
1. I think the information presented in this course will help me in working with handicapped and delayed children in day care and preschool.	SA	A	S	D	SD
2. The methods used (group experiences, worksheets, lecture, brainstorming) were helpful for increasing my knowledge and understanding of the material.	SA	A	S	D	SD
3. The format and organization of this workshop was appropriate.	SA	A	S	D	SD
4. The handouts were useful as an instructional aid.	SA	A	S	D	SD
5. I would recommend another day care or preschool teacher to attend a course like this.	SA	A	S	D	SD
INSTRUCTOR					
6. The teacher(s) for this workshop answered my questions sufficiently.	SA	A	S	D	SD

Course Evaluation: Integrating the Developmentally Disabled Child Into Day Care and Preschool

		Strongly Agree	Agree	Somewhat	Disagree	Strongly Disagree
7.	The teacher(s) demonstrated a thorough knowledge and understanding of the subject(s) discussed.	SA	A	S	D	SD
8.	The teacher(s) individualized to meet the specific needs of the day care center that I work at.	SA	A	S	D	SD
9.	The teacher(s) demonstrated respect for people's feelings and worked in a non-judgmental manner.	SA	A	S	D	SD
10.	The teacher(s) made the workshop interesting and conveyed enthusiasm.	SA	A	S	D	SD

GENERAL

1. What did you like best about this course? Please be detailed.

2. What could have improved this course? Please be detailed.

3. Additional Comments:

Thank you for taking the time to fill out this Evaluation. Your input will provide useful feedback for planning and improving future coursework.

FEEDBACK FORM

1. Overall, I would rate the content in this notebook as

_____Excellent _____Good _____Fair _____Poor

2. Did you find the activities and ideas presented in this curriculum helpful?

3. Which activities did you try? Would you use them again?

4. General comments and suggestions for improvement.

5. How many students were involved?

6. I used this material in teaching:

_____Course _____Workshop _____Seminar

_____Inservice

Please mail to:

Patti Donsbach
5733 Restal St.
Madison, WI
53711
(608) 271-5430

APPENDIX B

HANDOUT 1 - DAY CARE AND PRESCHOOL STAFF QUESTIONNAIRE*

GENERAL/OPENING QUESTIONS

1. Indicate age range:
   a) under 20   b) 20-25   c) 26-35   d) 26-45
   e) 46 and over

2. Number of years experience as a teacher:
   a) 1-2   b) 3-5   c) 6 or more

3. How much contact have you had to handicapped children in a non-teaching capacity?
   a) none   b) some   c) often

4. How much contact have you had to handicapped children in a teaching capacity?
   a) none   b) some   c) often

5. Estimate your comfort level with handicapped children:
   a) comfortable   b) unsure

6. How much have you interacted with a parent of a handicapped youngster in a teaching capacity?
   a) none   b) some   c) often

7. How much have you interacted with a parent of a handicpaped youngster in a non-teaching capacity?
   a) none   b) some   c) often

8. Have parents of handicapped young children ever approached you requesting placement of their children in your day care center?
   a) never   b) sometimes (c) often

INDICATE "A" FOR AGREE AND "D" FOR DISAGREE

9. _____ Day care licensing regulations require accepting children into regular day care programs at parent's request. (AD)

10. _____ It is likely that handicapped and non-handicpapped peer-mates could be friends in an integrated setting. (SI)

11. _____ Commercial adaptive equipment and materials for teachers to use with handicapped children are not readily available. (AD)

12. _____ You can usually pick out the handicapped children in an integrated setting by the way the children look. (AT)

13. _____ Handicapped children are more likely to be discipline problems in regular classes than non-handicapped children. (AD)

14. _____ Separate day care centers should be established for handicpaped children to attend. (S/I)

15. _____ I would want my own handicapped preschool aged child in an integrated day care center. (AT)

16. _____ Integrating handicapped children will create a need for new and different equipment. (AD)

17. _____ It would be beneficial for my non-handicapped child to play with a handicapped peer. (S/I)

18. _____ Some handicapped children with severe disabilities should be placed in institutions. (AT)

19. _____ The presence of a child in a regular class slows down the educational progress of the non-handicapped peers. S/I)

20. _____ Unlike regular early childhood education teachers, special educations teachers, only, possess knowledge of special methods which promote the success of handicapped children. (T)

21. _____ Integrating handicapped children into regular classes would probably contribute to negative behavior patterns on the part of the non-handicapped.

22. _____ Educational programming which involves handicpaped children in a self-center who are available to assist in the process of integrating handicapped children. (AD)

23. _____ There are lots of resource people within a 25-mile radius of our day care center who are available to assist in the process of integrating handicapped children. (AD)

24. _____ Handicapped children have a right to public education in settings with non-handicapped peers. (AT)

25. _____ Integrating handicapped children will create a need for a revised curriculum. (II) (AD)

26. _____ Teachers will have to spend more time working with the handicapped children than with the non-handicapped children. (AD)

27. _____ The handicapped child will feel inadequate in the integrated classroom (I, 6) (S/I)

28. _____ Parents of non-handicapped children do not want their children educated with handicapped children and therefore integrated day care centers will lose children. (AD)

29. _____ Day care and preschool teachers have the training and competencies to teach handicapped children without the need for supportive services. (T)

30. _____ A lot of physical adaptations will have to be made within the classroom to accommodate handicapped children. (AD)

31. _____ You can usually pick out the handicapped children in an integrated setting by the way the children act. (AD)

32. _____ Normal children benefit when handicapped children are integrated into regular classes. (S/I)

33. _____ Parents of handicapped children should pay a higher tuition because of the specialized services that have to be provided for their children. (AD)

34. _____ The attitude of the teacher towards handicapped children is the most critical factor in successfully integrating handicapped children. (AT)

35. _____ I would want my own non-handicapped preschool aged child in an integrated day care center. (AT)

36. _____ It would be difficult to plan for handicappped children who spend some part of their week in special education programs in addition to our day care center. (II) (AD)

37. _____ Integrated settings will educate handicapped children as well, if not better than, segregated settings. (S/I)

38. _____ I see it as within my role as a day care provider to encourage the enrollment of all children whose parents wish that they attended this center. (AT)

*This instrument was developed through Project Mainstream and written by Marjorie Getz-Sheftel and Patricia Donsbach.

HANDOUT 2 - INTEGRATING HANDICAPPED CHILDREN INTO REGULAR CLASSROOMS

by

Mary Glockner
ERIC/ECE

(based on an interview with Dr. Jenny Klein,
Director of Educational Services, OCD)

> As more states begin mandating education for handicapped children, there is a definite trend toward integrating these children into regular day care, preschool and elementary classrooms rather than channeling them into separate programs. Since many persons involved in early education have had limited experience with handicapped children, we asked Dr. Jenny Klein, Director of Educational Services, OCD, (whose background includes extensive work in special education) to talk about some of the things teachers and child-care people might be thinking about as they begin working with handicapped children. The following article is based on Dr. Klein's comments.

"When you're working with a handicapped child," Dr. Klein says, "it is important to think of him first of all as a child more like other children than different.

"A handicapped child may have some very special needs related to his particular handicap," she says, "but his basic needs are the same as those of 'normal' children--especially the need to be accepted and loved and praised."

Dr. Klein believes firmly that integrating handicapped children into regular classrooms is a good idea. "If we want children to live in the real world, it is important for 'normal' and handicapped children to learn to accept, appreciate, and understand each other," she says.

There is always concern about how "normal" children in a classroom will accept the presence of handicapped children. "The key here," says Dr. Klein, "is for you to understand your own feelings, because your reactions and your behavior provide a model for the children. If you are fearful, if you worry about being rejected by a handicapped child you can't seem to reach at all, or if you make too much fuss over the special child, the other children may pick up your feelings."

In addition to underlining the importance of thinking of every child (both normal and handicapped) as an individual with special strengths and weaknesses and special needs, Dr. Klein offered a number of more specific suggestions:

Learn as much as you can about the specific handicaps of the child or children who will be in your care. You don't have to become an expert; but learning about the specific disabilities in a general way should help you sort out some of the truisms from the misconceptions. (For instance, if you expect to be working with a deaf child, make it a point to learn something about deafness and the typical kinds of things that may happen to deaf children.)

Make the most of the resources in your area. Take advantage of any workshops or inservice training offered. Visit a good special education program, and talk to other teachers who have worked with handicapped children.

You may want to contact one or more of the associations organized for specific handicaps, such as the National Society for Autistic Children, National Association of Hearings and Speech Agencies, or National Easter Seal Society for Crippled Children and Adults. Most of these organizations publish a newsletter and funish guides to background reading, teaching resources, workshops, etc. Another good source of information is the ERIC Clearinghouse on Exceptional Children, 1411 South Jefferson Highway, Suite

900, Arlington, Virginia 22202. (For additional sources, see end of article).

Arrange to talk to the parents of the handicapped at a prearranged time --not in front of the child. This is a good way to find out as quickly as you can about some of his favorite activities and toys and some of the things that seem to bother him. (For instance, if a child's mother tells you that her son is frightend by loud noises you can make arrangements ahead of time to have him out of the room when a rhythm band session is scheduled.) Find out if there are any specific situations which almost always trigger a negative reaction so you can avoid them.

Before the special child comes into the class on a regular basis, ask his mother to bring him into the classroom after school some day. In this way he can begin to get to know you and feel comfortable in the room. Encourage the child to explore and move around the room. Maybe you could arrange for one or two of the other children to come in toward the end of the visit.

Know what comes within the range of normal behavior for the age group you work with (it may be wider than you think). Knowing the problems of "normal" kids of this age might help remind you that the blind child in your group may be having a temper tantrum just because he's two, not necessarily because he's blind. Just as is the case with normal children, some handicapped children are easy to be with and some are difficult.

Phase the child in slowly. Give him a chance to adjust to you, the environment, and the other children. Plan to spend some time alone with the child each day so you can get to know him. Take your cues from the child: note what makes him comfortable or scared or beligerent. Don't ever tell a child to participate in an activity--let him watch if he doesn't want to take part. Encourage the mother to stay with the child a few days at first, and keep your schedule flexible. Being in a group situation and having to meet new demands might be very hard for the special child: he may not be ready to stay the whole morning at first.

If you expect to have two or three severely handicapped children in your care, don't introduce them all into your class at the same time. This would be expecting too much of you, the new children and the others in the class. You all need time to get used to each other.

Don't make a big production of telling the other children that a handicapped child will be joining the group. It is often a better idea to talk to just one or two of the children at a time, asking them to help you make the new child feel comfortable.

Keep your expectations positive, but realistic. Avoid the two extremes of asking for too much or too little. Don't continually tell a child that he could do a particular task if he would just try harder. You may be giving him the impression that he's a failure because he never quite makes it.

However, be equally careful not to overprotect the special child. (Some parents and teachers unconsciously want to keep the child dependent on them so he is spared the realities of the world.) Your aim should be to provide experiences in which the child has to reach as far as he can without being frustrated.

Capitalize one the special child's strong points. Plan to set up situations in which the handicapped child does well in a group. A mentally retarded boy might have some playground skills that other children can appreciate; a deaf girl might do well in dramatic play. Sometimes you can try teaming up a particular child with a handicapped child in a project where their talents would complement each other.

Try to help the handicapped child gradually learn to follow more of the rules as he shows that he is ready. (This may be hard if exceptions have always been made for the child, or if he has severe emotional problems.)

You might explain to children who seem bothered by Johnny's unpredictable behavior that he will eventually learn how to get along, but that at first the class will have to make some allowances. (It's important, too, to show a mother that while you are very lenient and stretch the rules when necessary, you feel confident that sooner or later a handicapped child *can* learn to adjust to the group.)

Know your own level of frustration, how much you can take. It's bad to be (or feel like) a martyr. Don't consider yourself a failure if you need to ask for help or send a child home occasionally. Keep in mind that some handicapped children have more difficulty than others in large groups. If you have a severely handicapped child and find that you're constantly worrying about how he's getting along, a parent or aide may be helpful. (Because if you suddenly spend a great deal of your time with one or two handicapped children, the other children in your care may feel jealous or hurt that you don't pay as much attention to them.)

If you're fortunate enough to have several volunteers, try to arrange for the same volunteer to work with a special child on a regular basis. (It might be very confusing to the child to have to relate to three or four different adults in addition to the teacher.)

Be honest in dealing with questions children ask. It's only natural for young children to notice handicaps or unusual behavior. You don't accomplish much by admonishing them not to stare or by ignoring their remarks and questions. If Sally says "Peter looks funny," you might say, "You think Peter looks funny. Peter does look *different*, but when you get to know him it won't seem important any more." Or you could point out that Mary Lou doesn't wiggle around because she wants to but because she has cerebral palsy. (You may want to explain that something happened before she was born that makes it hard for Mary Lou to keep still).

Be alert for any child in the group who seems to be cruel or overprotective. These children may need special attention. Try to find out what it is that may account for their behavior. Sometimes it may be caused by fear that something will happen to them, that they may become crippled or blind. (Especially if they've often heard warnings such as "you're going to fall out of that tree and break your leg.") Possibly you may have to allay a fear that has never been expressed.

It is likely that most of the children will react in some way--many of them openly--to the special child. Use these reactions as opportunities to find out what sorts of things the children are thinking about and to answer questions they may have.

Working with Parents

Dr. Klein emphasizes the importance of providing encouragement and support to parents of handicapped children, pointing out that these parents have some special problems of their own which people who work with their children ought to be aware of.

For instance, mothers usually learn a great deal about what's normal for children from casual conversations with other mothers. But a mother can't compare notes with her neighbors on children's general growth and development if her child is blind and there are no other blind children nearby. The mother may be wondering why her daughter isn't walking: Because she is blind? Because she is just a late walker? Because she has an additional handicap? If her autistic child isn't toilet-trained yet, the mother may not know whether it is because she is not trained yet, the right way or whether something else is wrong.

Another problem for these parents is that often their handicapped child cannot communicate well. When their child doesn't talk at all, or cannot be understood, they have difficulty knowing how to react.

"Encouage parents to come into the classroom," Dr. Klein advises. "You can often pick up many ideas and insights from a mother on what her child needs or why he behaves the way he does. In addition, the mother will be able to understand better what sorts of things you are doing with her child, and learn that her child can function as part of a group much of the time despite some limitations.

Group discussion meetings arranged for these parents can provide a forum during which they can learn to deal with their own feelings and talk to other parents who have experience some of the same sort of probems in dealing with attitudes of neighbors, and neighbor's children, babysitters, and older children in the family.

If handicapped children are to have the greatest possible opportunities for continued growth and development, it is important for parents and teachers to communicate and support each other. Together they may be able to provide the experiences which realistically take into consideration the children's limitations but encourage them to reach out toward their fullest capacities.

HANDOUT 3 - CHECKLIST FOR MAINSTREAMING

Things to do before a child with a handicap is enrolled:

- Meet with parents.
- Have the child and parents come to the center for a visit.
- Complete an intake form which pinpoints the child's development in the different areas (motor, self-help, cognitive, language, social emotional).
- Talk to other teachers, therapists, doctors who know the child well.
- Meet with center staff to discuss the child's enrollment.
- Determine the resources available to the center that can be used for staff training and care for the child.
- Plan activities for the children that increase the acceptance of individual differences and handicapping conditions.
- Visit the child's home for additional information and support to the parents.
- Provide the opportunity to discuss the benefits of mainstreaming with all parents.

Things to do after the child with a handicap is enrolled:

- Continually assess the quality and degree of interaction between the children at the center.
- Continue to promote acceptance of individual differences.
- Set up times and methods to exchange information with the child's parents.
- Determine objectives for the child and monitor the child's progress.
- Coordinate programming with other professionals who are involved with the child.
- Have center staff meet regularly to discuss concerns and problems relating to the care of the child.
- Utilize resources in the community to develop skills and obtain materials or adaptive equipment.

HANDOUT 4 - PROBLEM SOLVING & VALUES CLARIFICATION

1. To maximize normalization and integration we should treat a handicapped child as normal unless there is a special need that normal situations do not List two examples of situations where a child has special needs that absolutely necessitates your treating or teaching him in a special manner. For each example explain how you would handle it in the most normative way.

2. In working with regular staff how would you handle the following situations in order to encourage maximum normalization and integration:
   a. A center teacher feels she qualified to teach a "special child
   b. A teacher of the center makes too much fuss over the "special child
   c. A teacher feels she is a failure because a child is still delayed even though she has worked as hard as she can with him.
   d. A center teacher who resents having to make special (different or extra) efforts to help handicapped children when the teacher has so many other things that require attention.
   e. A center teacher who feels the handicapped child will feel too much pressure when surrounded constantly by children so much more able than him.
   f. A center teacher who fears the normal children will pick up inappropriate behavior or undesirable mannerisms from the child with handicaps.
   g. A center teacher who uses "special" teaching techniques with the delayed child even when the technique used with normal children would have been effective.

3. True or False
   Why?

   a. When you're working with a handicapped child, it is important to think of him first of all as a child, then of his special needs.
   b. When working with a handicapped child, it is important to realize that he is more different from than he is like other children.
   c. In addition to having some special needs related to his particular handicap, a handicapped child has different basic needs than those of other children.
   d. Often children learn more from others their "own size" than they do from teachers, so teachers need to be concerned about "integrating" a normal child with a handicapped child in projects where their talents or needs complement each other.
   e. Any successful day care preschool program for normal children can be a successful program for children with handicaps.
   f. You should ignore remarks and questions normal children ask about particular handicaps.

g. Children with handicaps have some special needs but they have many more needs that are common to all children.
h. Education for the child with special needs should be very much the same as education for normal children, but certain adaptations and modifications to the regular program may be required.
i. Successful integration of children with special needs into the regular early education program is largely a matter of the teacher's attitude and normal "good-teaching" program.
j. Every child is an individual with special strengths and weaknesses, but only handicapped children have special needs.
k. Learning, in a general way, about the disabilities of a child who will be in your care is important because it will help you sort out some of the truths from the misconceptions.

4. Complete the following:
   a. The primary purpose for placing delayed children with normal children is ____
   b. A child will act more normally if he is treated ____________________
   c. The teacher's attitude toward the child with special needs will be ______________________________ by the other children.

HANDOUT 5 - UNDERSTANDING INDIVIDUAL DIFFERENCES

CHILDREN'S BOOKS

Ages 3-8

*Brightman, Alan, Like Me, Little, Brown & Co., 1976/2.95, available at Creative Learning Center, Middleton & University Bookstore.
Excellent - Deals with children's attitudes towards disabilities. Color photographs of young children playing and a simple text which describes children who are more like other children than different.

Caudill, Rebecca, Certain Small Shepherd, Holt, N.Y., 1965.
A young mountain boy who cannot speak is the center of a touching story.

Fanshawe, Elizabeth, Rachel, Bradbury Press, 1977/4.95. Available from Helen C. White Children's Library.
A colorful picture book for very young children provides glimpses of Rachel's life, who is in a wheelchair. Normalcy is the emphasis throughout.

Fassler, Joan, One Little Girl, N.Y., 1969/6.95, available from Human Sciences Press, 72 Fifth Ave., N.Y. 10011.
A picturebook for story telling, about a 6 year old mildly retarded child.

Forrai, Maria, A Look at Physical Handicaps, and A Look at Mental Retardation, Lerner Publications, 1976/4.95, available at Helen C. White Children's Libaray.
Black and white photographs, and an easy text provides information in these non-fiction books.

Guggenheim, Hans, The World of Wonderful Difference, Friendly House Publishers, New York, 1960.
An imaginative blend of verse & illustrations on the wonder & worth of differences among people.

*Green, M., Is it Hard? Is It Easy?, Reading, Mass., Addison-Weslay, 1960/4.95

Heide, Florence, Sound of Sunshine, Sound of Rain, Parents Magazine Press, N.Y., 1970.
The thoughts and feelings of a blind child, presented with sensitivity.

*Lasker, Joe, He's My Brother, Albert Whitman Co., Chicago, 1974.
A picturebook which gives a simple, good explanation of a little boy with learning disabilities.

Levine, Edna, Lisa & Her Soundless World, Human Sciences Press, 1974, available at Central WI Center library and from Helen C. White Children's Library. $4.95
Provides good information about the problems and education of the deaf child, and how to learn to play with hearing children. Excellent.

Naylor, Phyllis, Jennifer Jean, the Cross-eyed Queen, Lerner Publishing Co., Minneapolis, Minn., 1967
A little girl's concerns over being different.

Peterson, Jeanne, I Have a Sister, My Sister is Deaf, Harper, 1977/4.95, available at Helen C. White Children's Library.
Appealing and perceptive portrait of a young deaf child. Excellent.

Rasking, Ellen, Spectacles, Atheneum, N.Y., 1968.
Clever pictures alternate clear vision with effects of nearsightedness in an unusual story to ease adjustment to glasses.

*Sara Bonnett Stein, About Handicaps, Walker & Company, N.Y., 1974.
An "open family" book.

*Wolf, Bernard, Don't Feel Sorry for Paul, Lippencott Company, N.Y., 1974.
A 7 year old boy born with birth defects adjusts to life and prosthetic devices. Beautiful photographs.

A Button in Her Ear/4.50, available from Childcraft, 70 Kilmer Road, Edison N.J. 07817.
A child with a hearing deficiency is portrayed realistically and informatively

Ages 6-11

Brightman, Alan, Like Me, Little, Brown, and Co., Boston.
A child's own story of what it feels like to be retarded.

Christopher, Matthew, Long Shot for Paul, Little, Brown & Co., Boston, Mass.
Story of a boy's determination to help his mentally retarded brother gain friendship and athletic skills.

Cleaver, Vera and Bill, Me too, Lippincott; Philadelphia, 1973, $8.95.
Lydia and Lorna are twins. Lorna is a nuisance and an embarrassment to Lydia. One day, Lydia fools a neighbor into thinking that she is Lorna. After this incident, Lydia understands Lorna better and begins to accept her sister more.

Davidson, Margaret, Helen Keller, Hastings House, New York, 1971.
The story of her triumph over deafness and blindness.

Fassler, Joan, Howie Helps Himself, A. Whitman & Company, Chicago, 1975/4.25 available at Helen C. White Children's Library and Central WI Center Library.
Picturebook about a child with cerebral palsy whose emotions can be recognized by all children no matter what their experience with handicaps has been. Presents a positive view. Excellent.

Gardner, Richard, The Children's Book about Brain Injury, Massachussets Association for Children with Learning Disabilities, Framingham, Mass. 1966.

Gelfand and Patterson, They Wouldn't Quit, Lerner publishing Company, Minneapolis, Minn., 1962.
Stories of successful adults who had special needs.

Gold, Phyllis, Please Don't Say Hello, $6.95, available from N.A.D., 814 Thayer Avenue, Silver Springs, MD 20910
One night a little deaf girl is visited by a song - a beautiful fantasy.

*Grealish, Charles, The Sneely Mouth Snerds and the Wonderoctopus, Human Policy Press, Syracuse, New York, 1975, $1.75

The Snerds pick on each other, call names, and are scared of differences among them. A fun story with a fine ending.

Hayes, Marvell, Tuned in - Turned on, Academic Therapy, San Rafael, CA, 1974.

A book about kids with learning disabilities.

Hunter, Edith, Child of the Silent night, Dell Publishing Company, New York, 1971.

The inspiring story of a little girl born deaf and blind, who learned to communicate.

Larsen, Hanne, Don t Forget Tom, Crowell; New York, 1978, $7.89.

A straightforward and empathetic text about Tom, a 6 year old, who wants to do all the things other children his age do.

Little, Jean Take Wing, Little, Brown, Boston, $7.95.

Laurel's ambivalent feeling of love and resentment toward caring for her 7 year old mentally retarded brother are described.

Little, Jean, Mine for Keeps, Little, Brown & Company, Boston, Mass. 1962.

The life of a girl with cerebral palsy who starts to attend regular school - realistic, with good illustrations.

Patterson, Katheryn, No Time For Tears, Johnson Publishing Company, Chicago, 1965, $3.95

Biography of a hydrocephalic.

Peterson, Jeanne, I Have a Sister My Sister is Deaf, Harper 1977, $4.95. Available from N.A.D., 814 Thayer Avenue, Silver Springs, MD 20910 and from Helen C. White Children's Library.

Appealing and perceptive portrait of a yong deaf child. Excellent.

Robinson, Veronica, David in Silence, Lippincott, Philadelphia, PA., 1965.

David was deaf and found a friend who made an effort to understand.

Sackmary, Arnold and Zeeman, Roger. Special People: Basic Facts to Help Children Accept Their Handicapped Peers. Convent Station, NJ: New Jersey Association for Children with Learning Disabilities, 1973. (P.O. Box 249)

Sobol, Harriet, My Brother Steven is Retarded. Macmillan, New York, 1977, $5.95.

Beth is 7. Steven is older than she, but he is smaller. Beth narrates the good and bad times she has with her brother.

Swieringa, Do it My Way, Grand Rapids, MI, Institute for the Development of Creative Child Care, 1973.

Describes how people do and should interact with the blind.

Vance, Marguerite, Windows for Rosemary, Dutton, New York, 1968

Feelings of children are explored through the story of a girl who is blind.

Boker, Dea, Alike-But Unalike, recognizing the similarities and differences in pupils, Danville, IL 1974.

Very good - talks about MR children in the school system.

Children's Films

Chesler, B., A Walk in Another Pair of Shoes, California Association for Neurologically Handicapped Children, Los Angeles, Cal., 1972/18 Minutes/ color

Describe how it feels to be a child with learning disabilities. 35 mm filmstrip or 35 mm slides with synchronized audio-cassette tape.

David & Goliath, and Noah, Northridge, CA, Joyce Motion Picture Company/ 18 minutes/color/16 mm.

Beautiful fims in which both voice and signs are used.

Records

"Getting Through: A Guide to Better Understanding of the Hard of Hearing". Chicago, Zenith Radio Corporation, 1971.

"How They Hear: The Sounds of Abnormal Hearing". Northbrook, IL, Gordon Stowe and Associates, 1964.

Both present everyday speech as it sounds to people with various types of and degrees of hearing impairments - an excellent experience. Available at Central WI Center Library.

HANDOUT 6 - DISABILITIES QUIZ

		Yes	No	Not Sure
1.	Is a person with a disability usually sick?			
2.	Can a person who is blind go to the store?			
3.	If someone can't talk, do you think he's retarded?			
4.	Were people with disabilities born that way?			
5.	Do you feel sorry for someone who is disabled?			
6.	Can blind people hear the same as other people?			
7.	If a person is retarded, does it mean that he/she will never grow up?			
8.	Are all deaf people alike?			
9.	Can a person in a wheelchair be a teacher?			
10.	Do all children have a right to go to your school?			

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HANDOUT 7 - DISABILITY QUIZ #2

1. A diagnosis of autism is based on
    - a. detection of an extra chromosome
    - b. observable behaviors
    - c. parent-child interactions
    - d. I.Q. testing

2. Autism is a disorder appearing
    - a. before 3 years of age
    - b. in school age children
    - c. in adolescence
    - d. in later adulthood

3. A person with autism will often
    - a. have physical deformities
    - b. have an imaginary playmate and act out fantasies
    - c. form close friendships based on non-verbal communication
    - d. be resistant to change in the environment

4. According to the currently accepted definition, a developmental disability must be manifest
    - a. during the developing years and affect physical development
    - b. at birth and affect mental development
    - c. during the developing years and expected to continue indefinitely
    - d. during the developing years and involve progressive deterioration

5. Cerebral palsy results from damage to the __________ before, during or after birth.
    - a. muscles
    - b. spinal column
    - c. brain
    - d. genes

6. Cerebral palsy is most typically distinguished from other disabilities by
    - a. behavioral problems
    - b. visual and auditory problems
    - c. motor problems
    - d. learning problems

7. The primary barrier for persons with cerebral palsy in realizing their intellectual potential is
    - a. mental development problems
    - b. communication difficulties
    - c. behavioral problems
    - d. lack of motivation

8. Most mental retardation can be prevented
    - a. true
    - b. false

Disability Quiz #2 (cont.)

9. Language development, self-direction, and vocational activity are all examples of the individual's
   a. motor skills
   b. adaptive behavior
   c. emotional adjustment
   d. mental health

10. Which of the following is a medical problem associated with Down's Syndrome?
   a. low resistance to infection
   b. dry skin
   c. dental problems
   d. all of the above

11. A seizure is caused by
   a. abnormal muscle contraction
   b. too little blood reaching the brain
   c. an abnormal electrical discharge in the brain

12. The majority of people with epilepsy have normal intelligence.
   a. true
   b. false

*Questions for this quiz were selected from the Orientation to Developmental Disabilities and Community Living Series developed by New Concepts for the Handicapped Foundation, Inc. - Middleton, Wisconsin. Reprinted with permission.

Key - Answers for Disability Quiz #2
1-b, 2-a, 3-d, 4-c, 5-c, 6-c, 7-b, 8-a, 9-b, 10-d, 11-c, 12-a.

HANDOUT 8 DISABILITY DESCRIPTION FORM

DEFINITION:

INCIDENCE & PREVALENCE:

CAUSES:

MANAGEMENT & PREVENTION:

HANDOUT 9 - SPECIAL TECHNIQUES

I. SPECIAL TECHNIQUES: HEALTH IMPAIRMENTS

Some common health impairments are epilepsy or convulsive disorders, pituitary problems, hypothyroidism, diabetes, asthma, congenital heart defects, anemia, hemophilia.

A. Prepare for emergency situations by talking to parents or the child's doctor.
   1. Be aware of what may cause a crisis and how often it may occur.
   2. Be aware of how the child may behave before a crisis.
   3. Know what behaviors the child is likely to demonstrate during and after crisis, and how long it usually lasts.
   4. Ask the parent/doctor to describe, demonstrate or train you in what you are to do during and following the crisis. Can you do it alone or should you summon help? (p. 33)
   5. Prepare a list of your classroom activities; ask child's doctor to check activities which must be avoided and to describe modifications/alternatives so the child can participate.
   6. Prepare other children for possible health crises by giving them a simple explanation when discussing other emergencies; assure children that the staff will be able to handle all such situations.

B. Develop activities that include health impaired children.
   1. Allow the children to do things for themselves.
   2. Some children will need more rest, but do not restrict a child from any activity unless there is a clear physical or emotional danger.
   3. Help children, who are fearful of doctors, hospitals, or separation from parents, feel secure by establishing a classroom routine.
   4. Help children, who have been confined at home or in the hopsital, learn to share/cooperate/play in a group of children.

II. SPECIAL TECHNIQUES: SPEECH AND LANGUAGE IMPAIRMENTS

A. Help the children feel secure by reacting positively when child uses existing communication skills.

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B. Be a good listener:
   1. Ask parents for help in understanding child.
   2. Help others in class understand the child.

C. Get the Children talking:
   1. Talk to the children while they are doing something.
   2. Encourage the children to bring in special things from home
   3. Encourage the children to talk about how they feel.
   4. Let the children do as many different things in the classroom as possible, to give them more to talk about.
   5. Teach the children (if posssible) how to give important information, such as their name and address.
   6. Teach the children a short rhyme or song they can perform for others.
   7. Include in your program vocabulary, concepts, and activities that are relevant to very child's home experience and cultural background.
   8. Ask the children open-ended rather than yes-no questions. (p. 82)

D. Input comes before output:
   1. Model correct communciation skills and provide child with many opportunities to practice them.
   2. Don't demand a verbal response; provide the correct answer if the child does not.

E. Helping children with language impairments:
   1. Help them understand by getting their attention, using language that is appropriate to their level, using names for objects or places you are talking about, repeating questions or adding gestures or physical aid to help the child respond to what is said.
   2. Expand on what children say.
   3. Model new sentences; pair something new with the familiar.
   4. Encourage children to imitate.
   5. Talk about what you or children are doing.

F. Helping children with serious articulation problems:
   1. Learn to understand what children say; ask parents for help and, if necessary, ask child to repeat or "show".
   2. Teach children how to listen--to recognize the source of sounds and to identify sounds which are alike and different.
   3. Model good articulation patterns.
   4. Keep in touch with speech-language therapist so you will know which skills specific children are working on.

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G. Helping children with voice disorders:
  1. Check with diagnostician to find out the cause.
  2. Discourage vocal abuse.
  3. Be a good model.
  4. Have children try out different voices during a play.

H. Helping Children Who Stutter:
  1. Set a good example; speak quietly and calmly.
  2. Establish favorable speech conditions.
    a. Provide opportunities for child to speak without pressure or interruptions.
    b. Don't criticize; show that you understand what child has said.
    c. Find out when children feel most comfortable and are most fluent.
    d. Don't tell children what to do to stop stuttering.

III. SPECIAL TECHNIQUES: EMOTIONAL DISTURBANCE

"A child shall be considered seriously emotionally disturbed who is identified by professionally qualified personnel (psychologist or psychiatrist) as requiring special services. This definition would include but not be limited to the following conditions: Dangerously aggressive towards others, self-destructive, severely withdrawn and non-communicative, hyperactive to the extent that it affects adaptive behavior, severely anxious, depressed or phobic.
(p. 33)

A. Helping the aggressive child:
  1. Follow a routine for arrivals and departures.
  2 Before a transition, give several reminders that the activity will be changing.
  3. Encourage the child to express his feelings in words, not actions. Pick out an activity or area where child can work out anger.
  4. Remind the child if he or she is losing control and prompt appropriate behaviors.
  5. During group activities (circle, story, etc.) give the child enough personal space; seat the child in between non-aggressive children or near adult.
  6. Control the child's level of stimulation by removing unused materials, slowing down activity, or introducing quiet activity.

B. Helping the anxious child:
  1. Prepare the child for new activities by exploring the activity or area beforehand.
  2. In group activities, seat the child between non-aggressive children; encourage but don't force participation.
  3. Help the child understand that it is more important to try an activity than to do it perfectly. (p. 106)

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3. Allow the child to work at own pace.
4. Help the child recognize when he or she is becoming anxious and seek help from adults.

C. Helping the hyperactive child:
1. Give short, clear, and calm directions about transitions and throughout activities; provide adult supervision.
2. Control level of excitement; remind the child when he or she is losing control.
3. During group activites, call on the child frequently to keep his or her attention.
4. Use demonstrations to keep child's attention.
5. Don't expect prolonged sitting -- break tasks into small segments that can be done in a short time.
6. Gradually increase the amount of time you expect the child to attend to and perform tasks.

D. Helping the withdrawn child:
1. Encourage and support participation, but allow the child to watch and listen.
2. Respond positively to the child's attempts to communicate in order to build self-confidence.
3. Provide the child with individual attention and instruction.
4. Gradually involve the child in a few simple activities; introduce other other children into these activities gradually.

IV. SPECIAL TECHNIQUES: ORTHOPEDIC HANDICAPS

Orthodpedic handicaps may be the result of cerebral palsy, spinal cord damage, arthritis, amputations, severe burns, muscular dystrophy.

A. Positioning: The child needs to feel comfortable and well balanced in order to concentrate on learning activities. Get help from the physical therapist or parents. Consider the following questions when positioning:
1. Given the physical strengths and weaknesses of each child, where should the activity occur?
2. In what position will each child have maximum freedom to see what she or he is doing and to move arms and legs.
3. How should each child stand? Freely? In a supported, stationary position?
4. How should each child sit? In a chair? Supported on the floor? 'Indian style' with material in his or her lap? In a wheelchair at a table?
5. Should a child lie on one side? Lie on the floor with a bolster under the chest to free the arms and hands?" (p. 91)

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B. Mechanical Aids and Equipment
   1. Wheelchairs, walkers, wheeled carts, canes, or crutches help children to get around the building, classroom, and playground.
   2. ...braces, helmets, artificial limbs, and specific self-help aids... help a particular child eat, communicate, play, and perform other activities of daily living as independently as possible." (p. 58)

C. Equipment Modification
   1. Modify seating arrangements when necessary to provide support to the head, legs, and trunk.
   2. A child who tires easily when sitting or standing might be placed on the floor with chest and arms over a bolster or wedge so that arms can be used freely.
   3. Modify tables to accommodate wheel chairs by removing ledge under table or raising it; otherwise place tray over chair's arms.
   4. Be sure there is enough room between furniture groupings to accommodate crutches, walkers, or wheel chairs.

V. SPECIAL TECHNIQUES: HEARING IMPAIRMENTS

Find out from parent and/or special education teacher which teaching methods and communication system (oral vs. total communication approach) is being used with the child so you can be supportive.

A. Speaking to a Child:
   1. Learn how close you must be to a child in order to be understood.
   2. Get at eye level so your face can be seen.
   3. Speak at normal speed and volume.
   4. Don't exaggerate lip movement.
   5. Use same vocabulary and sentence structure as you would with other children; repeat, rephrase, point out, and demonstrate if child does not understand.
   6. Sit child close to teacher in a group.
   7. Teach other children to look at hearing impaired child when they speak and how to get child's attention.
   8. Talk about what the child, other children or you are doing.

B. Giving Directions:
   1. Get child's attention.
   2. Make sure child understands directions; if necessary, repeat or demonstrate while speaking.

C. Helping a Child Talk:
   1. Always wait for a response.
   2. Model, ask child to imitate, but don't pressure.

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3. Introduce new words that fit child's activity.
4. Fill-in or expand on child's incomplete sentences.
5. Tell the child if his or her voice is too loud or soft.
6. Model correct pronunication; don't correct the child but reward speaking.

D. Listening to a Child:
1. Encourage speech in group activities, allowing time for child to start and finish speaking.
2. Respond to child's communication by making appropriate comments if you understand; ask child to repeat or ask "What" or to "Show me" if you don't understand.

E. Helping a Child Listen and Understand:
1. Periodically check child's hearing aid.
2. Help child notice sounds by pointing out what makes sound or prompting child to attend.
3. Provide many entertaining opportunities for listening.

VI. SPECIAL TECHNIQUES: MENTAL RETARDATION

A. Here are some steps you can take to help children develop a better self-concept:
1. Structure activities so that the child feels successful. Break them down into as many small steps as needed for success.
2. Praise progress, no matter how small.
3. Try to be positive about failures. 'You tried very hard. With such good practice, I'm sure you'll learn how to do that soon.'
4. Be patient when it is necessary to show a child how to do something many times.
5. Be tender, accepting, and loving.
6. Concentrate on a child's strengths, not weaknesses. Use those strengths to the child's best advantage.
7. Fit the activity to the child, so that it is challenging but not overwhelming.
8. Be consistent about what you are expecting from a child.
9. Make the child responsible for a part of the classroom routine, and praise his or her reliability.
10. Never allow other children to make fun of a child.
11. Include each child as fully as possible in all activities. Isolation hurts.
12. Give each child the opportunity to show off a little such as displaying drawings. When a child is proud of something, show it to others. (p. 72)

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3. Tips for carrying out activities:
    1. Reduce noise and clutter.
    2. Give simple directions.
    3. Show how to do tasks.
    4. Provide physical help, if necessary.
    5. Keep activities short.
    6. Follow a routine daily.
    7. Provide for many opportunities for practice.
    8. Teach in small steps -- not too fast.
    9. Reward child for efforts and accomplishments with something child likes.

C. Prepare children for transitions -- time between activities -- by giving an advance warning.

D. Help children with language problems: See suggestions in Speech and Language section.

VII. SPECIAL TECHNIQUES: VISUAL HANDICAPS

A. Sensory Training: Teach child to use other senses -- tactile, auditory kinesthetic (body position and movement), taste and smell-to get information.

B. Teach the partially sighted to use remaining vision.
    1. Block out unnecessary light.
    2. Speak and perform demonstration where child can clearly see avoiding glare.
    3. Teach colors of common objects.
    4. Use simple, bold pictures.
    5. Seat child up close.
    6. Encourage child to hold objects at angle and distance that is best for seeing.

C. Train children with little or no vision in orientation and mobility so they can move and function independently; teach them to determine the distance and direction of sounds.

D. Steps to Promote Learning:
    1. Encourage using vision.
    2. Encourage participation by having child move near activities.
    3. Provide clear explanations of all activities.
    4. Provide concrete experiences; use touch or physically move the child through new activities.
    5. Teach child correct postures for sitting, standing, gestures.
    6. Arouse curiosity through multiple sensory experiences.
    7. Signal activity changes verbally.
    8. Express your feeling to the child physically.
    9. Keep the active.

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GENERAL TEACHING TECHNIQUES:
MAINSTREAMING PRESCHOOLERS WITH HANDICAPS

A. Classroom Personnel:
   1. Aides
      a. Include them in developing educational objectives and ongoing planning for children.
      b. Agree on aides' responsibilities; provide directions and reinforcement.
      c. Aides should share responsibility for providing individual attention to meet special needs of a child, but avoid separating child from group too often.
   2. Volunteers: Give explanations and directions about what you want them to do with individual children.

B. Setting Limits:
   1. State safety limits simply and frequently, demonstrate them, and consistently enforce them.
   2. Clearly state and consistently enforce behavior limits to control behaviors which disrupt the learning of other children or interfere with the child's learning.
   3. Change an unacceptable behavior by finding a good substitute.

C. Pacing:
   1. Vary activities between active and quiet, as well as between organized and free play.
   2. Present new skills in familiar contexts.

D. Grouping:
   1. Make use of "peer modeling" by pairing the handicapped child with a more-skilled child in areas where s(he) is weak and with a less skilled child in areas where s(he) excels.
   2. Do not exclude the child with special needs from activities; give extra assistance, change expectations, or modify the materials.

E. Children Helping Children:
   1. Non-handicapped children can help in mainstreaming by
      a. introducing a new child to the physical setting of the classroom.
      b. helping a confused child organize his or her materials.
      c. providing a child with opportunities to practice a newly learned skill.
      d. assisting a poorly coordinated child during playground games.
      e. alerting a child whose attention wanders that a teacher is about to give a direction.
      f. sitting close to an easily frightened child to provide support when the lights go out during a film-strip."
      (These points appear in Chapter Four of each Manual.)

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2. Dont't allow helpers to do "too much" for a handicapped child.

F. Breaking Down Skills:
   1. Every skill is composed of a sequence of subskills.
   2. If a child cannot perform one or more of the subskills, teach the subskills needed for success at the over all activity.

G. Sequencing Activities: Sequence subskills that make up a skill or activity, as well as a series of activities so that they gradually increase in difficulty.

H. Physical Contact and Guidance: Use physical contact to ensure safety, to help a child learn a new skill, or to limit space.

I. Avoiding Over-Dependence:
   1. Provide assistance only when necessary; be realistic about what children are capable of doing themselves.
   2. Be patient and give extra encouragement to children who try things on their own.

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HANDOUT 10 - COMMUNITY RESOURCES

NAME OF AGENCY (address, telephone, contact person):

SERVICES:

AREA SERVED:

CONTACTS AND COMMENTS

HANDOUT 11 - GLOSSARY OF TERMINOLOGY

ADAPTIVE BEHAVIOR - the standards of personal independence and social responsibility expected of a person at a given age and within a specific cultural group. The capacity to adjust to simple problem situations.

ADVOCACY - activities relating to support or advice for parents and/or children with handicaps with regard to programming.

ANOMALY - anything unusual or irregular or different from the general rule; usually refers to some physical characteristic. A congenital anomaly is one that happens to a baby before he is born and is usually diagnosed at birth.

APGAR SCORE - a scale devised by Dr. Virginia Apgar to measure a newborn baby's vital signs at birth and right after birth.

APHASIA - a disorder of language learning; the loss of the ability to express or understand language symbols (the spoken or written word) as a result of some central nervous system dysfunction. It can be expressive (or "motor"), in which the person can understand but cannot give back appropriate responses; receptive (or "sensory"), in which the person cannot understand language he hears or sees; or both. Congenital aphasia means language did not develop at all, rather than that it was once developed and then lost.

ARTICULATION - the ability to enunciate speech sounds accurately.

ATAXIA - muscle incoordination that shows itself, during a purposeful movement, by irregularity and lack of precision.

ATHETOID - a type of cerebral palsy characterized by writhing, involuntary movements of the muscles, usually involving part of an arm or leg (hand or foot). Such movement stops during sleep.

AUDIOLOGIST - the person who is trained to evaluate, diagnose, and treat hearing problems.

AVERSIVE BEHAVIOR - avoidance behavior.

BEHAVIOR MODIFICATION - an approach to changing behavior by understanding and manipulating the external, social, or behavioral forces that operate on a person. The belief is that a person is likely to repeat behavior that is followed by a pleasant or gratifying experience. Therefore, emphasis is placed on giving positive reinforcements (rewards) for desirable behavior; a form of operant conditioning.

CHRONOLOGICAL AGE - sometimes referred to as CA, it means the actual number of years a person has lived.

CLEFT LIP - A congenital defect in which a fissure exists in the upper lip.

CLEFT PALATE - A congenital defect in which a longitudinal fissure exists in the roof of the mouth.

COGNITIVE ACTIVITIES - activities during which the ability to think, question and solve problems is utilized.

CONFIDENTIALITY - with the exception of certain individuals such as school officials and teachers with legitimate educational interests, no one may see the records of a handicapped child unless the parent gives written permission.

CONGENITAL - any mental or physical trait or condition that exists at birth because of something that happened to the fetus during the time it was in the womb; it may or may not be hereditary.

CONVULSION - violent involuntary contracting and relaxing of the muscles; spasms.

CROSSING THE MIDLINE - ability to perform tasks requiring the eyes or hands to cross the midline of the body (i.e., touching the right ear with the left hand).

CYSTIC FIBROSIS - a congenital metabolic disorder in which the body gives off certain abnormal secretions that are carried throughout the body in the blood. Symptoms usually appear in early childhood. The disease is chronic and degenerative, with no known cure. It is usually found only in Caucasians.

DEVELOPMENTAL DISABILITY - a developmental disability is a severe, chronic disability of a person which: 1) is attributable to a mental or physical impairment or combination of mental and physical impairments; 2) is manifested before the person attains age 22; 3) is likely to continue indefinitely; 4) results in substantial functional limitations in three or more of the following areas of major life activity: a) self-care, b) receptive and expressive language, c) learning, d) mobility, e) self-direction, f) capacity for independent living, and g) economic self-sufficiency; and 5) reflects the person's need for a combination and sequence of special, interdisciplinary or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

D.P.I. - stands for the Department of Public Instruction.

DOWN'S SYNDROME - a commonly recognized form of mental retardation caused by imperfect chromosome formation and characterized by low mentality and abnormal body features.

DYSFUNCTION - absence of complete normal function; differs from paralysis in which there is loss of function.

DYSLEXIA - a severe reading disability; an impairment, usually due to central nervous system dysfunction, associated with printed symbols. It is estimated that between 3% to 7% of the population of the United States has some dyslexia. Boys seem to outnumber girls almost 3 to 1.

HANDOUT 11 - GLOSSARY OF TERMINOLOGY (continued)

DYSLEXIA (continued)
The dyslexic child often sees letters or numbers reversed (this is normal in children of a certain age but then passes); he may not be able to tell differences between words he hears that sound somewhat alike; he may have problems with size and shape discriminations (big, small, a square, a circle). All of these factors affect the ability to learn to read.

DYSTROPHY - weakness and degeneration of muscle.

EARLY INTERVENTION - refers to programming for children as soon as possible. It is hoped that by beginning very early in a child's life he or she can benefit greatly by achieving more. Many programs begin helping parents and children at birth.

EEG - an electroencephalogram, a record of electrical activity of brain useful in studying some forms of mental or brain disturbance.

EC:EEN - this stands for Early Childhood: Exceptional Education Needs which is the public school program for 3-5 year old children with handicaps.

ECHOLALIA - the meaningless repetition of words; the involuntary repetition of a word or phrase just spoken by another person. It is common in the speech of very young children. At a later age, it may be associated with some disorder.

ETIOLOGY - the cause of an illness, disease, or condition.

EXCEPTIONAL CHILD - a child who differs intellectually, physically, socially, or emotionally to the extent that he cannot receive maximum benefit from a regular school program. He requires a special class of supplementary instruction and services. Sometimes incorrectly used to describe an exceptionally bright child. Correct term would be gifted child.

EXPRESSIVE COMMUNICATION - the actual speech a child utters.

EXTENSION - straightening of body parts; used in therapy reports.

EXTREMITIES - an arm or leg; sometimes specifically hand or foot.

FACILITATE - to promote or hasten the natural process; reverse of inhibit.

FLEXION - bending; term is used in therapy reports.

GAIT - the way one walks. Many brain damaged children have what is called an "awkward gait."

HEMIPLEGIA - paralysis of the arm and leg on one side of the body.

HEREDITY - the characteristics, conditions, or traits passed down in a family from parents to children.

HANDOUT 11 - GLOSSARY OF TERMINOLOGY (continued)

HOME TRAINING - a program to help parents in care and training of young handicapped children at home.

HYDROCEPHALY - a condition of increased secretion of serum into the cranial spaces with a possible consequence of pressure to such a point that the brain may be damaged.

HYPERACTIVE - hyperkinesis - term used to describe children who are always moving, in constant motion, unable to control activity.

I.E.P. - stands for Individual Educational Plan. Each child involved in a special education program is required by law to have one of these plans stating goals and objectives for the child. The I.E.P. may be developed cooperatively by teachers, parents, clinicians, therapists, and administrators.

INCIDENCE - range of occurrence or influence of a condition or disease.

I.Q. - (intelligence quotient) - intellectual functioning assessed by standard tests; relative to rest of population in any particular age group.

MICROCEPHALY - a condition of mental retardation characterized by a head that is greatly diminished in size; generally the face is of near normal size.

MID-LINE - an artificial line running down the center of the body.

MOTOR ACTIVITIES - a) gross motor - activities such as walking, running, swimming, climbing stairs, etc., which contribute to development of large muscles and their skills; b) fine motor - activities such as placing pegs in a peg board, stringing beads, cutting with scissors, printing, etc., which contribute to development of small muscles and their skills.

MULTIDISCIPLINARY TEAM (M-TEAM) - refers to a process of bringing together professionals and parents in order to plan a program for a child.

MULTIPLE HANDICAP - term used to indicate the presence of two or more handicapping conditions.

NEUROLOGIST - a physician whose area is neurological problems, or problems of the central nervous system.

NORM - an average, common or standard performance.

NORMALIZATION - a movement which stresses that a person who is handicpaped should be able to live and experience life at the most normal level possible.

OCCUPATIONAL THERAPY - treatment given to improve movement for daily living.

PARAPLEGIA - paralysis of lower part of body, including both legs.

PASSIVE MOVEMENT - when an individual has body parts moved through range of motion by outside force.

HANDOUT 11 - GLOSSARY OF TERMINOLOGY (continued)

PERCEPTION - the process of becoming aware of objects, qualities, or relations.

PKU (Phenylketonuria) - a condition due to an inborn error of protein metabolism; a specific enzyme in the blood or liver which metabolizes an amino acid found in many foods is lacking, causing this amino acid to collect in large amount in the blood stream preventing normal mental development.

PHYSICAL THERAPIST - a person skilled and specially trained in treatment of the body by massage or exercise, as prescribed by the physiatrist.

P.L. 94-142 - the Education for all Handicapped Children Act signed into law in 1975 by President Ford. It requires among other things that handicapped children be educated in the least restrictive environment. It also guarantees due process, and requires a written IEP.

PRIMITIVE RESPONSES - or primitive reflexes usually appear in the early months of life and disappear soon thereafter.

PRONE POSITION - refers to child lying on stomach.

QUADRIPLEGIA - paralysis of the body involving arms and legs.

RECEPTIVE COMMUNICATION - area of language usage related only to understanding meanings of words. The first step to oral language comprehension.

RESPITE CARE - a program which offers temporary care of children who are handicapped so that their parents can have some free time.

RETALIN - a drug used in treatment of hyperactive children.

RIGIDITY - very stiff movements and posture.

SCOLIOSIS - an appreciable sideways deviation in the normally straight vertical line of the spine.

SENSORIMOTOR - motor responses to sensory stimuli (visual, auditory, tactile, etc.). As the child grows and develops, these responses become refined, less random, and thus skilled.

SHUNT - tube implanted to drain excess fluid from the brain to another part of the body.

SOCIALIZATION - the act or process of relating with one other person or a group of people.

SPASM - sudden tightening of muscles.

STAFFING - refers to discussion of a child's abilities to aid in program planning.

SUPINE POSITION - refers to child lying on back.

HANDOUT 11 - GLOSSARY OF TERMINOLOGY (continued)

SYMMETRICAL - both sides of the body acting the same.

TASK ANALYSIS - refers to breaking down an activity into smaller steps.

TONE - firmness of muscles.

VESTIBULAR STIMULATION - therapeutic technique used in the remediation of sensory integrative dysfunctions; involves such activities as rapid spinning, rolling, etc.

VISUAL ACUITY - sharpness of vision.

W-SITTING POSITION - refers to child sitting with knees bent, child is resting on haunches (inappropriate position).

WEIGHT-BEARING - on a joint or joints may be inhibitory or facilitatory to the muscles surrounding--body weight or less is inhibitory, more than body is facilitatory.

* * * * *

HANDOUT 12 - WORKSHEET DISABILITIES INTERPRETATION

1. In order to arrive at findings for the M-Team, Sandra was assessed by the entire Interdisciplinary Team, P. T., O. T., and EC:EEN staff. The EEN is concerned about the conflicting E.E.G. reports and would like to request another one before an IEP is developed. Also attached is a report from D.P.I. concerning parental comment with regard to P.L. 94-142 and Least Restrictive Alternative.

2. According to the Binet, Jimmy seems to be functioning well below his age level in both receptive and expressive skills. This is due to his Aphasia. It is obvious that Early Intervention has helped him; however, his Adaptive Behavior still needs improvement.

HANDOUT 13 - CONSULTANTS IN DAYCARE

WHAT IS THE PURPOSE OF TECHNICAL ASSISTANCE?

One purpose of the technical assistance or consultation is to aid in problem definition and problem solving. A second purpose is to increase the knowledge and skill of the staff who have requested assistance. A time limited, voluntary relationship is formed for a specific purpose. Not all technical assistance persons offer exactly the same range of services. It is important to be clear at the very beginning about mutual expectations. The clearer the terms of the agreement are, the more useful the process will be.

WHAT TO EXPECT WHEN YOU ASK FOR TECHNICAL ASSISTANCE?

A consultation might provide the following services:

observation
curriculum development
values clarification
environmental design
goal definition
support
feedback
program evaluation
children assessment
presentation of alternatives
group process skills
advising
researching a question
referral
facilitating communication
community planning
in service training
supervising skills

A consultant will look beyond the child to attempt to understand the difficulties the child is having. The physical environment, the daily activities, staff expectations, or demands made by other children may all be explored. A center may be asked to make changes to see what effect these changes have on a child, the staff, or the program. Cooperation of all staff will be necessary for success.

WHAT NOT TO EXPECT WHEN YOU ASK FOR TECHNICAL ASSISTANCE.

A consultant would NOT:

*provide child care
*give orders
*supervise
*discipline
* do therapy
* take sides
* make decisions

WHAT THE CONSULTANT EXPECTS FROM YOU.

1. Initiate contact.

2. Have the support of those who will be assisted. Staff, parents and administrators should all be informed and be willing.

3. Get parental permission when the matter concerns individual children. Inform parents that their child is being observed. You may want to use a simple written permission form. State licensing rules require written consent in order for staff to share information on file.

4. Choose one consultant. There may be several people who could be asked but it is confusing and counterproductive to get advice from many different sources without a coordinated effort. A discussion with a potential consultant may help you decide which person to use.

5. Retain primary responsibility. A consultant can assist, advise, and provide alternative solutions. Only you can choose or reject suggestions and carry through any mutually agreed upon plan. Either you or the consultant can terminate the agreement.

HOW TO GET HELP WHEN YOU ARE CONCERNED ABOUT A CHILD.

1. Use your own resources first. Define the issue clearly and pull together related information. If you work with others, do this as a team. Observe the child carefully. Be sure to notice strengths and positive behaviors as well as questions and problems. Next pinpoint your concerns and the changes you feel are necessary. Consider changes you could make in the environment or program or yourselves. If you do not have the chance to do this or if you feel that you need assistance, go on to the next step. Sometimes a director or another staff person can observe and help you define the issue. Some consultants can observe as part of their service.

2. Contact the parents. You may talk with parents as part of your own problem-solving attempt. Find out whether similar problems have occurred at home and how parents have coped with them. This will give you lots of information concerning management techniques already tried, the parenting style the child is accustomed to, and parents' problem-solving style. Also, parents may be handling the problem at home quite successfully and may be able to help you out. If the problem is not resolved at this point, the teacher's concerns about the child and classroom should be stated and consultation should be recommended. Recognizing that the problem is multifaceted is a good way to avoid labeling the child or the parents as the source of the problem.

   Parent permission is necessary before you call in outside help. If you have a comfortable relationship with these parents, you will probably know how best to ask. Calling in a consultant is often threatening to parents. Sometimes it helps to explain it in terms of your being stuck and wanting help. Other times you will need a meeting. Then it is usually best to involve any adults that are in the home. Do what you need to do in order to make yourself comfortable in this meeting. Approach the meeting as a time for problem-solving. Use descriptive language when describing the problem to the parents. State frequency of occurrence ("he often hits 3 or 4 children in the course of a morning") and approximately how long the child's behavior has been a problem. Describe the resource you have in mind.

   If parents refuse to give permission, you and other appropriate staff have a decision to make. You may not be able to keep the child without help. The particular child's needs and those of the other children and the staff must be weighed carefully.

3. Choose a consultant. If you have not yet involved an outside resource and all have agreed, it is appropriate to call somebody you already know and trust, or look at the chart. Be prepared to describe the problem briefly and what has been done so far. Have exact age and other information ready. Then, enter into an agreement with the consultant.

HOW TO GET HELP WHEN YOUR CONCERNS ARE ABOUT YOUR PROGRAM OR ABOUT YOURSELVES

Program-centered. Consultation or technical assistance can be obtained for program concerns and could focus on environment, activity planning, group dynamics, parent meetings, or other daily concerns.

Staff-centered. The director and staff may ask for help in assessing or handling their own work difficulties. For example, this could involve staff relationships or upgrading skills and knowledge.

Administration consultation. This may be obtained to assist those with overall program responsibility. It may concern financial matters, functioning of a center, planning, supervisory skills, or community relations.

1. Define your concerns. Know what the issues are; where you get stuck; and what you want to change. This in itself may be difficult; if so, the consultant may assist you in this necessary step.

2. Who to involve. Different types of consultation may call for different procedures. In any case, it is always important to have those adults who are involved define the issues and make a decision that outside help is needed. Program, staff, and administrative centered consultation probably will not call for parental consent. It is important for the coordinator in the decision to get assistance for the program or staff. This involvement will be very important later when support or resources are needed for implementing any change. Usually in the case of administrative consultation, and often in the case of program or staff-centered consultation, a board of directors needs to be involved. For the same reasons--for support and release resources--a board can be notified or asked to approve any major request for outside help. This depends on the particular program's policies for staff, director, and board.

3. Call a consultant. Call someone you can trust. It may be someone you know, someone recommended, or someone from the chart. Describe your problems briefly and concisely. Tell the consultant what kind of help you want. Then, enter into an agreement with the consultant.

REMEMBER PROBLEM SOLVING TAKES TIME!

Be prepared to spend time identifying one or more approaches. Try them out for an agreed upon period of time. Evaluate the effects with the consultant. Be honest with the consultant. If you are having problems implementing a strategy because of time, or staff, or other program restraints, share this information. Effective problem solving requires involvement of the necessary people, commitment to solving the problem, and a willingness to change. Programs for children can be improved through an effective partnership between a Center and the right consultant.

This material was prepared by members of the Training and Technical Assistance Caucus, 4C - Community Coordinated Child Care, Dane County, Wisconsin. Printed with Permission.

HANDOUT 14 - DEVELOPMENTAL CHECKLIST *
by Verna Hart, Ed. D.

Name STEVEN
Birthdate ______
Date of First Evaluation ______
Age 3½ years
Date of Second Evaluation ______
Age ______
Date of Third Evaluation ______
Age ______
Date of Fourth Evaluation ______
Age ______

Developmental Age

	1st Evaluation	2nd Evaluation	3rd Evaluation	4th Evaluation
Gross Motor				
Fine Motor				
Percept				
Emotional				
Social				
Communication				
Self Help				
Eating				
Toileting				
Dressing				
Other				

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Gross Motor

_____ 1 month _____ Exhibits asymmetric tonic neck reflex (fencing position)
_____ Lifts chin up slightly when lying in the prone (face down) position.
_____ Protective reflex-free foot pushes aginst stimulus when other foot is pushed.
_____ Startles to loud noises or sudden movement.
_____ 2 months _____ Lifts head for 3 or more seconds when lying prone.
_____ Holds head erect for 3 or more seconds when in upright position.
_____ Raises head and shoulders off table with fore arms when lying on stomach.
_____ Righting reaction - attempts to return to midline when head is turned from mid-center position.
_____ 3 months _____ Lifts head slightly when on back.
_____ Rolls from side to back.
_____ Sits with support, head steady, for 10 seconds.
_____ 4 months _____ Holds back firm while hips are supported in sitting position.
_____ When prone, lifts head and chest up off table.
_____ Holds head erect continously while sitting supported.
_____ 5 months _____ Turns head freely when sitting in chair.
_____ No asymmetric tonic neck reflex (fencing position).
_____ Rolls over on side from back position by rotating upper part of the body, flexing hips and throwing leg to same side.
_____ Sits supported on high chair.
_____ 6 months _____ Can turn from back to stomach.
_____ Plays with toes. (_____ Puts arms forward if tips forward sitting.)
_____ First crawling reaction -- Pushes on hands, draws up knees, etc.
_____ 7 months _____ Held standing, will bear weight and bounce actively.
_____ Rotates by moving shoulders first, rather than head.
_____ Can roll from back to stomach and from stomach to back.
_____ Sits briefly, 10 seconds, while leaning forward on hands.
_____ 8 months _____ Tries to crawl, using both hands and feet--abdomen touching floor. (_____ Puts arms out to catch himself if he falls sidways)
_____ Sits alone for one minute.
_____ Can support entire weight on legs for short period when held up.
_____ Pivots on abdomen, using arms, up to 90°.
_____ 9 months _____ Can pivot 180° when left lying on the floor.
_____ Crawls forward and backward.
_____ Sits steadily unsupported for longer than 3 minutes.
_____10 months _____ Stands when held up.
_____ Sits in a chair without leaning, arm protection backwards.
_____ Pulls self to a sitting position or crawling position.
_____11 months _____ Can stand holding onto furniture.
_____ Creeps on hands and knees--abdomen off floor, reciprocal movements.
_____ Sidesteps, holding onto furniture.
_____ Leads with hips when turning over.
_____12 months _____ Stands alone for thirty seconds, may rock in standing position.
_____ Can walk, adult holding one or both hands. (_____ Full external rotation and protective extension of arms)
_____ Throws or rolls a ball.
_____13 months _____ Climbs onto one step while he is crawling.

_____13 months _____ Can stand alone one minute.
_____ Can lower self from standing to sitting by holding onto support.
_____14 months _____ Walks without support for three steps, areas in high-guard position.
_____ Can kneel with balance on floor or chair.
_____ Supports his weight on the entire sole surface.
_____15 months _____ Crawls up stairs.
_____ Walks, pushing large wheeled toy.
_____ Stands self up using support.
_____17 months _____ Can stoop to pick up toy without losing balance.
_____ Climbs into a low chair.
_____ Walks about well with an immature gait, arms lowered to waistline.
_____18 months _____ Pulls and pushes toys while walking.
_____ Throws ball overhand without falling.
_____ Can walk while carrying a doll or toy.
_____19 months _____ Climbs stairs holding rail.
_____ Goes downstairs creeping backwards.
_____ Walks in adult manner no longer using stiff-legged position to maintain balance, arms in low-guard position.
_____20 months _____ Beginning to jump, but unable to clear floor.
_____ Beginning to run.
_____ Pushes chair about and climbs on it.
_____21 months _____ Walks backwards three steps.
_____ Runs without falling, jumps well three times, clearing floor, feet not together.
_____ Climbs and stands up on chiar.
_____ 2 years _____ Climbs purposely on chair.
_____ Walks up and down steps alone--2 feet per step.
_____ Can kick a ball.
_____2.5 years _____ Walks on tiptoes four steps.
_____ Jumps down with both feet from 8" step.
_____ Can carry breakable object ten steps.
_____ 3 years _____ Can stand on one foot for three seconds.
_____ Jumps off floor with feet together.
_____ Goes up stairs with one foot per step.
_____ Catches large ball with arms out straight.
_____ Rides tricycle.
_____ Walks a line for ten feet.
_____ 4 years _____ Can jump up and down, feet together, five times.
_____ Hops on one foot four times.
_____ Can carry a cup of water ten feet without spilling.
_____ Catches a large ball with elbows bent.
_____ Alternates feet going downstairs.
_____ Can skip on one foot.
_____ 5 years _____ Can skip, alternating feet.
_____ Broad jump.
_____ Marches in time to music.
_____ Shifts body to keep balance when throwing a ball.

Fine Motor

_____ 1 month _____ Fanning movement of fingers of both hands.
_____ Thumb has characteristic curled-up position.
_____ Clenches or opens fist on contact.
_____ 3 months _____ Holds rattle for 4 seconds when its placed in hand.
_____ Brings hands to mouth.
_____ Disapearance of grasp reflex.
_____ Plays with hands.
_____ Hand regard.
_____ 4 months _____ Thumb does not participate when grasping 2" cube.
_____ Hands come together.
_____ Mouths objects--puts everything in mouth.
_____ 5 months _____ Approach to objects is two handed.
_____ Grasp is limited to large objects.
_____ Reaches.
_____ 6 months _____ Uses hand to reach, grasp, crumble, bang or splash.
_____ Makes scooping motion in grasping pellet.
_____ Thumb opposes in grasping 1" cube.
_____ 7 months _____ Transfers objects from one hand to another.
_____ Releases object only against resistant surface.
_____ Hands cross midline.
_____ One hand approach to 1" cube.
_____ 9 months _____ Bangs objects together.
_____ Drops for release.
_____ Pincer grasp using full thumb and forefinger.
_____ Looks up while playing with toys.
_____10 months _____ Explores parts of a toy, probes holes, and grooves.
_____ Release objects deliberately.
_____ Goes for object with index finger.
_____12 months _____ Places cube in a container.
_____ Pincer grasp of raisin.
_____ Palmer grasp of crayon.
_____ Mouthing stops.
_____15 months _____ Helps turn book pages.
_____ Places objects in and out of containers.
_____18 months _____ Holds two objects in one hand.
_____ Turns book pages, two or three at a time.
_____ Removes objects from bag.
_____ Maintains wide open hand until contact with object is made.
_____21 months _____ Puts large pegs in pegboard.
_____ 2 years _____ Fits toys together.
_____ Preference for handedness.
_____ Begins to extend fingers toward point of writing instrument.
_____ Unscrew lids.
_____ Turns doorknob back.
_____ Turns book pages singly.
_____ 3 years _____ Uses scissors to chop paper.
_____ Draws and names simple figures.
_____ Strings beads.
_____ Can pluck object from table top without touching table top.
_____ Reaches for object without having to look directly at it.
_____ Draws a man with head and legs
_____ May shift handedness.

_____	4 years	_____	Can draw a man with six parts.
		_____	Holds hand above or to one side so as not to obstruct view of what he builds.
		_____	Independent use of both hands in building.
		_____	Cuts with scissors.
_____	5 years	_____	Can print a few letters.
		_____	Uses scissors to cut on line.
		_____	Grasps in adult manner--fingers curved into palms.

Perceptual

_____	Neonate	_____	Attends longer to patterns than solids.
		_____	Sucks sweet, mintlike flavors.
		_____	Grimaces at bitter, sour, or salty tastes.
_____	1 month	_____	Responds to loud noises by crying or startling.
		_____	Quiets and reduces activity due to approaching sound.
		_____	Follows horizontal movement or light or bright object to midline.
_____	2 months	_____	Attends, stops or changes activity in response to human voice.
		_____	Accepts loud noises as part of the environment.
		_____	Follows object past midline.
_____	3 months	_____	Glances in response to peripheral stimulation.
		_____	Has control of eye muscles.
		_____	Stares at toy when placed in hand.
_____	4 months	_____	Pays particular attention to tones of voices.
		_____	Localizes sound laterally by looking at source.
		_____	Looks intently at object in hand or in front of him.
_____	5 months	_____	Looks after toy dropped in sight.
		_____	Smiles at mirror image.
_____	6 months	_____	Responds differently to friendly and angry voices.
		_____	Fixates where objects disappeared.
		_____	Prefers solid sphere to flat objects.
		_____	Plays peek-a-boo.
		_____	Pats mirror image.
_____	7 months	_____	Looks for fallen objects.
		_____	Finds partially hidden object.
		_____	Localizes sound by moving head in sweeping arc.
_____	8 months	_____	Responds to name.
		_____	Drops one of two toys to take a third one offered.
_____	9 months	_____	Picks up string or object the size of a small pea between thumb and finger.
		_____	Picks up, pokes at tiny bits.
_____	10 months	_____	Waves bye-bye and plays pat-a-cake.
		_____	Gives and takes objects on command with gestures.
		_____	Feels surfaces and textures with fingers and palms.
_____	11 months	_____	Reaches for image of toy in mirror.
		_____	Puts toy inside box or cup, but will not release.
		_____	Plays serially with several toys.
_____	12 months	_____	Responds to sound toys, music.
		_____	Pushes circle into form board.
		_____	Places rings on pegs.

_____ 18 months _____ Points to familiar objects named by adults.
_____ Responds to two simple commands.
_____ Can point to 2, 3 body parts.
_____ Imitates mother's common chores.
_____ 2 years _____ Recalls events of previous day.
_____ Listens to stories.
_____ Increased visual memory span--looks for missing toys.
_____ 3 years _____ Can choose between 2 alternatives.
_____ Matches mounted colors.
_____ Puts two halves of a picture together.
_____ Matches forms by inserting circle, square, triangle in cut-out forms even with reversal of position.
_____ 4 years _____ Discriminates noisemakers.
_____ Matches sound blocks by loudness.
_____ Completes a picture of a man.
_____ Matches forms.
_____ Compares sizes.
_____ Discriminates lengths of lines.
_____ Traces diamond between parallel lines.
_____ Copies circle, ends joining.
_____ Copies cross
_____ 5 years _____ Carries a melody.
_____ Claps in rhythm to a song.
_____ Follows and repeats sequence of a story.
_____ Distinguishes between left and right.
_____ Can select middle-sized objects.
_____ Can insert sequence of testing blocks.
_____ Can name most colors.

Drawing

_____ 18 mos. _____ Scribbles spontaneously.
_____ Imitates vertical stroke.
_____ 2 years _____ Imitates horizontal stroke.
_____ Imitates v stroke.
_____ 3 years _____ Copies circle.
_____ Copies cross.
_____ Draws a man.
_____ 4 years _____ Copies a square.
_____ Traces a diamond.
_____ 5 years _____ Copies a triangle.
_____ Copies diamonds and rectangle with diagonal.

Cube Building

_____ 15 mos. _____ 2 cube tower.
_____ 18 mos. _____ 3 cube tower.
_____ 21 mos. _____ 5 cube tower.
_____ 2 years _____ 6 cube tower.
_____ 3 blocks horizontally.
_____ 2½ years _____ 8 cube tower.
_____ 3 years _____ 10 cube tower.

Puzzles

_____ 18 mos. _____ Round shape.
_____ 3 years _____ Square shape.
_____ Triangle shape.
_____ Turns pieces to fit.

Conceptual

_____ 1 month _____ Basic sensory responses.
_____ Responds to light.
_____ Responds to sound.
_____ Responds to taste.
_____ Responds to touch.
_____ 4-8 mos. _____ Puts motor meaning to objects.
_____ Beginning of object permanence.
_____ Means to an end beginning to develop - may use one object to move another.
_____ 9-12 mos. _____ Beginning of symbolic meaning.
_____ Overpermanence of objects -- looks in 1st hand after he's seen object transferred to second hand.
_____ First indication of causality.
_____ 12 months _____ Overpermanence disappears.
_____ Pats pictures of objects when named.
_____ 15-18 mos. _____ Development of space perception.
_____ Trial and error process begins.
_____ Causality.
_____ 15 mos.- 2 years _____ Formulates negative judgment.
_____ Object permanence.
_____ Says "no" on high plane of logic.
_____ 2½ years _____ Understands "in".
_____ Understands "under".
_____ Can answer: "What do you do with _____?"
_____ 3 years _____ Understands "in front of".
_____ Understands "behind".
_____ Can pick the longest line.
_____ Knows "big" and "little".
_____ Knows "hard" and "soft".
_____ Can classify objects by physical attributes.
_____ 4 years _____ Counts from 1 to 10.
_____ Knows 1-3 colors accurately.
_____ Can count 3 objects.
_____ Can compare weights.
_____ Understands money is for purchasing.
_____ Defines objects by their use.
_____ Can classify objects by groups.
_____ 5 years _____ Can classify objects on the basis of function.
_____ Knows names of most colors.
_____ Counts four objects.
_____ Can make aesthetic comparisons.
_____ Developing a left to right concept - is right 50%.
_____ Can tell how many fingers on each hand.
_____ 6 years _____ Classifies by association.

Emotional

_____	1 month	_____	Emotional response to distress begins.
_____	2 months	_____	Emotional response to delight.
		_____	Squeals of pleasure.
_____	3 months	_____	Recognizes familiar faces, smiles.
		_____	May sober at seeing strangers.
_____	4 months	_____	Laughs aloud, smiles, sobers.
_____	5 months	_____	Emotional response becomes relative to specific situation.
_____	6 months	_____	Fear response to less of support, sudden loud noises.
_____	7 months	_____	Distress differentiates into more specific responses of fear, disgust, etc.
		_____	Delight differentiates into elation, affection.
		_____	Amuses self for short intervals - 5-10 minutes.
_____	10 months	_____	Shows distrust of strangers, may cry.
		_____	Sleeps through night.
_____	12 months	_____	Aggressive interaction with environment begins.
		_____	Willfully disobedient.
		_____	Shows fear, anger, affection,jealousy, anxiety, sympathy.
_____	18 months	_____	Sleeps through night.
		_____	Negativism--does opposite of what he is told.
_____	2 years	_____	Enjoys toy telephone--pretend to "read" newspaper
		_____	Curious and busy.
		_____	Use I, me, you.
		_____	Emotional arousal sudden, brief and intense--temper tantrums.
		_____	Can call himself by his own name.
_____	2½ years	_____	Differentiates facial expressions of anger, sorrow, and joy.
		_____	Possessive with toys.
		_____	Rigid insistence on routine.
_____	3 years	_____	Beginning of imaginative and make believe play.
		_____	Shows sympathy in response to accidents, bandages, etc.
		_____	Jealousy toward siblings.
		_____	Sacrifices immediate satisfaction for promise of later privilege.
		_____	Begins to use words to express feelings.
_____	4 years	_____	Aggressive both physically and verbally.
		_____	May be rough and careless with toys.
		_____	Fabricates, alibies, rationalizes.
_____	5 years	_____	Sparked into increased activity by rivalry.

Social

_____ 1 month _____ Quiet when picked up.
_____ Eye contact.
_____ 2 months _____ Smiles at mother in response to smile, voice, physical care.
_____ 3 months _____ Babbles when spoken to.
_____ Recognizes mother.
_____ Enjoys evening play with father.
_____ 4 months _____ Cries if adult stops playing with him.
_____ Smiles at approach of mother.
_____ 5 months _____ Cries if adult stops playing with him.
_____ Stretches arms out to be taken.
_____ 6 months _____ Smiles and vocalizes at mirror image.
_____ Discriminates strangers, may cry.
_____ 7 months _____ Pats image of self in mirror.
_____ Goes to familiar person.
_____10 months _____ Able to play alone for an hour or so, but prefers company.
_____ Recognition of mirror image.
_____11 months _____ Offers toy to adults, but does not want to give it up.
_____ Enjoys dropping toys from playpen or chair to be retrieved by adult.
Increased affection and interest in family group.
_____12 months _____ Distinguished between "you" and "me".
_____ Gives object to another upon request.
_____13 months _____ Hugs and shows affection toward doll or teddy bear.
_____ Plays near other children.
_____ Varies behavior according to emotional reaction of others.
_____18 months _____ Imitates activities he observes.
_____ 2 years _____ Has mother-baby relationship with dolls.
_____ Rough, tumble play--solitary or parallel level--notices other children, but is self-centered.
_____ Separates readily from mother when handled properly.
_____ 3 years _____ Beginning to cooperate--shares toys, waits turn.
_____ Initiates own play.
_____ 3½ yrs. _____ Imaginary playmates.
_____ Temporary attachment to one playmate.
_____ 4 years _____ Cooperative level of play.
_____ Prefers 2-3 children.
_____ Calls people names -- "dumb".
_____ Plays well with one child or in supervised group.
_____ Aware of attitude of peers.
_____ 5 years _____ Dramatic play..
_____ Competitve play.
_____ Sensitive to social situations.
_____ Plays in groups.

Communication

_____ 1 month _____ Reflexive vocalizations.
_____ Throaty noises.
_____ Change in pitch--sign of bodily discomfort.
_____ 2 months _____ Single vowel sounds.
_____ Babbling begins, cooing, gurgling.
_____ Reflex activities produce sounds.
_____ Repeats sounds for physical pleasure and auditory stimulation.
_____ 3 months _____ Makes responsive sounds if one nods or talks to him.
_____ Laughs or squeals.
_____ Differentiated crying, changes with physical state.
_____ 4 months _____ Laughs aloud in response to others.
_____ Recognizes human voice.
_____ Localizes sounds.
_____ 5 months _____ High squeal.
_____ Vocal play.
_____ Indicate wants by crying.
_____ 6 months _____ Combines vowel and consonant sounds, such as: ma, da.
_____ Talks and gestures to objects.
_____ Jargon with change in tone.
_____ 7 months _____ Listens to own voice.
_____ Says mum-mum-mum, especially when crying.
_____ Makes vowel sounds in a series.
_____ Deep sounds and grunts.
_____ Vocalizes emotional state.
_____ 8-9 mos. _____ Single consonant sounds.
_____ Tongue play.
_____ Combines syllables.
_____ Bites and chews toys.
_____ Copies sounds.
_____ May have vocabulary of 1-2 words.
_____ 10 months _____ "Mama" and "Daddy" with meaning.
_____ Uses voice tone symbolically.
_____ Meaningful attempt at conversation.
_____ 12 months _____ Understands phrases and wholes.
_____ Responds by action to command.
_____ Echolalia.
_____ 1 word sentences.
_____ Understands gestures.
_____ Listens to words carefully.
_____ Attracts attention by squealing.
_____ Has 2 words besides mama and dada.
_____ 13-15 mos. _____ Understands very simple commands.
_____ Imitates words.
_____ Vocabulary of 3-4 words.
_____ Communication by gestures.
_____ 15 months _____ Indicates needs by pointing or vocalizing.
_____ 18 months _____ Vocabulary of 10 words.
_____ Jargon directed at people.
_____ Understands simple questions.

_____ 20 mos. _____ Recognizes many pictures he cannot name.
_____ Pulls for communication.
_____ Imitates animal and toy sounds.
_____ 20-24 mos. _____ Says goodbye to indicate termination.
_____ Uses one word for many unrelated things--extension of meaning.
_____ Recognizes 120-275 words.
_____ 2 years _____ Vocabulary of 200-300 words.
_____ Combines 2-3 words to express ideas.
_____ Uses a few adjectives, prepositions, and pronouns "me" and "mine".
_____ 2½ years _____ Verbalizes simple emotions and experiences.
_____ Speech with pointing.
_____ 1.8 words sentences.
_____ Starts to use short sentences.
_____ Comprehends time words.
_____ Uses plurals.
_____ 3 years _____ Questions begin.
_____ Uses compound sentence structure.
_____ Uses complex sentence structure.
_____ Responds by action to:
    _____ on
    _____ under
    _____ down
    _____ run
    _____ walk

_____ Names objects.
_____ Verbal reasoning can be used.
_____ Vocabulary of 600-1000 words.
_____ Knows his sex.
_____ Knows his full name.
_____ 3-4 word sentences.
_____ Asks questions about persons, places, and processes.
_____ Uses pronouns, some adjectives, adverbs, and prepositioning.
_____ Final consonants appear.
_____ Sounds include blends.
_____ Speech is 90-100% intelligible.
_____ Knows a few rhymes.
_____ 4 years _____ Abundant questions--"why" and "how".
_____ Speech is understandable to outsiders.
_____ Vocabulary of 1500 words.
_____ Actively conceptualizes.
_____ Completes sentences of 6-8 words.
_____ Uses "we".
_____ Alludes to persons and places outside of immediate environment.
_____ Advancing sentence structure--uses articles.
_____ Follows 2 stage commands.
_____ 5 years _____ Talks clearly.
_____ Adult speech sounds.
_____ Has mastered basic grammar.
_____ Relates a story.
_____ 2000 word vocabulary.
_____ Meaningful questions.

_____ Can be given 2-3 assignments at one time and will carry out in order.
_____ Relates fanciful tales and past and present events.
_____ Likes to look at books and be read to.
_____ Language becomes symbolic.

Self Help Skills

Eating

_____ 3 months _____ Opens mouth for approaching food.
_____ 4 months _____ Anticipates on sight of food.
_____ 6 months _____ Holds bottle.
_____ Takes strained food well.
_____ 7 months _____ Feeds self biscuit.
_____ Chews food.
_____ 9 months _____ Can feed himself bottle--removes and puts into mouth.
_____10 months _____ Accepts new solid food.
_____ Finger feeds.
_____ Eats mashed table foods.
_____15 months _____ Grasps spoon and inserts into dish.
_____ Turns spoon upside down before it enters mouth.
_____ Holds cups with finger grasp, but apt to tip it too quickly.
_____18 months _____ Fills spoon and feeds self in part, spills much.
_____ Turns spoon in mouth.
_____ Lifts cup to mouth and drinks well.
_____ Requires assistance in feeding.
_____ Hands empty cup to mother.
_____ All jaw movements lift, rotate, grind, chew, bite.
_____ Holds glass with 2 hands.
_____21 months _____ Handles cup with ease, lifting, drinking and replacing.
_____ 2 years _____ Stops turning of spoon before it gets to mouth, still need help in feeding.
_____ Lays aside spoon and lifts dish to drain liquid at end of feeding.
Holds small glass in one hand as he drinks.
_____ 2½ years _____ Little spilling in self feeding.
_____ 3 years _____ Pours well from a pitcher.
_____ Uses straw.
_____ Feeds self.
_____ Clears and cleans table.
_____ 4 years _____ Likes to serve self at table.
_____ Eats with fork.
_____ Spreads with knife.
_____ Rarely needs assistance to complete a meal.
_____ 5 years _____ Cuts with knife.

Toileting

_____ 7 months _____ Intervals of dryness 1-2 hours.
_____12 months _____ Dryness after nap.
_____ Fusses until changed.
_____ Intolerance of wetness at certain times.
_____15 months _____ Does not indicate toilet needs, but does indicate wet pants.
_____ Bladder retention span 2-3 hours.

_____ 18 months _____ Toilet regulated in day time--both bowel and bladder.
_____ 21 months _____ Asks for food, toilet, and drink by gesture or word.
_____ Tells after wetting--and sometimes before.
_____ 2 years _____ Dry at night if taken up at least once.
_____ Verbalizes or signs toilet needs consistently.
_____ 2½ yrs. _____ Tends toilet without help except wiping.
_____ Many be dry for about 5 hours.
_____ 3 years _____ Few accidents.
_____ May be dry all night.

Dressing

_____ 15 months _____ Attempts to put on clothes.
_____ Cooperates in dressing by extending arm or leg.
_____ 18 months _____ Can take off mittens.
_____ Can take off hat.
_____ Can take off socks.
_____ Can take off shoes.
_____ Can unzip zippers.
_____ Tries to put on shoes.
_____ 2 years _____ Pulls on simple garments, finds large armholes and thrusts arms into them.
_____ Pulls on socks.
_____ Can remove shoes if laces are untied.
_____ Removes coats.
_____ 2½ years _____ Tries to unbutton-button within reach.
_____ 3 years _____ Puts on shoes--may be on wrong foot.
_____ Puts on underpants and slacks.
_____ Unbuttons front and side buttons by pushing them thru buttonholes.
_____ 4 years _____ Dresses and undresses if lightly supervised.
_____ Can snap clothing.
_____ Distinguishes front and back of clothes and puts on correctly.
_____ Can zip clothing.
_____ Laces shoes.
_____ 5 years _____ Dressses self except for belts and tying shoes.
_____ 6 years _____ Ties shoe laces.
_____ Can handle all fasteners in any position while dressing.

Other

_____ 9 months _____ Guards face to prevent washing.
_____ 12 months _____ Runs washcloth over face and center of body.
_____ 2 years _____ Washes face and front of body.
_____ Rinses off soap--dries self in front.
_____ 2½ years _____ Attempts to brush teeth.
_____ Puts things away.
_____ 3 years _____ Washes and dries hands.
_____ Can clear and clean table.
_____ Turns water on.
_____ Sleeps at nap time until 3 years.

_____ 3½ years _____ Puts away toys with some supervision.

_____ Washes and dries hands and face.

_____ 4 years _____ Brushes teeth.

_____ Puts away toys by himself.

_____ Goes on errands outside of home.

_____ 5 years _____ Can safely cross streets, if not too hazardous and can help a younger child to cross street.

_____ Combs and brushes hair.

HANDOUT 15 - DEVELOPMENTAL CHECKLIST

CASE STUDY DESCRIPTION: STEVEN, AGE 3½

Steven has been attending the center for about a month and the teacher has noticed that he is having some difficulties. He often falls when trying to run and seems off-balance some of the time. Steven is able to string beads and use a scissors in a chopping manner. He has difficulty listening during story time and cannot seem to carry out more than a two-step direction. He can count to five and knows the colors "red" and "blue". During free play, he chooses to draw although he scribbles most of the time. Steven is very willing to share his toys, is friendly towards other children and starts play activities with them. He has a large vocabulary but tends to use relatively simple sentences for communication. Steven rarely needs assistance during snack time. His mother reports he has very few toileting accidents at home.

Handout 16 - Sample program - Steven Age 3 1/2

DEVELOPMENTAL DOMAIN	BEHAVIORAL OBJECTIVE	ACTIVITIES FOR REACHING OBJECTIVE
GROSS MOTOR		
FINE MOTOR		
PERCEPTUAL		
CONCEPTUAL		
EMOTIONAL		
SOCIAL		
COMMUNICATION		
SELF-HELP		

HANDOUT 17 - CATEGORIES OF SOCIAL BEHAVIOR*

1. Unoccupied Behavior Category: The child occupies himself watching anything that happens to be of momentary interest. When there is nothing exciting taking place he self-stimulates or uses self-stimulating objects within his environment. Also, he sits in one area and does not interact with other children.

2. Solitary Independent Play: The child plays alone and independently with toys different from those being used by other children. He is within speaking distance of other children but makes no effort to interact with them. He pursues his own activity without reference to what others are doing. To facilitate the movement from unoccupied behavior into solitary independent play, the child is placed near other children and is encouraged to participate with a toy or an object. He is reinforced for manipulating that toy or object while sitting within that environment.

3. Adult Directed Behavior: This is behavior directed to an adult by the child. This includes such activities as playing with the teacher looking at the teacher, touching the teacher, or asking questions of the teacher. Interaction with the adult or teacher is encouraged or reinforced when a child is at the solitary play stage and does not interact with anyone. However, adult directed behavior should be changed as rapidly as possible to encourage the child to engage with his peer group.

4. Onlooker Category: Within this category the child spends most of his time watching other children play. He may talk to the other children who he is observing, but he does not overtly enter into the play himself. This differs from the unoccupied category in that the onlooker is definitely observing particular groups of children. The child stands or sits within speaking distance of the group so that he can see and hear everything that takes place. For the therapist to facilitate this behavior form either solitary independent play or adult directed behavior he must place the child within speaking distance of other children and reinforce any verbalization that occurs between the normal and handicapped children.

5. Parallel Activity: Within this category the child plays independently but the activity he chooses brings him among other children. He plays with toys that are like those which the children around him are using, but he plays with the toys as he sees fit, and does not try to influence or modify the activity of the children near him. He plays beside rather than with the other children. There is no attempt to control the coming or going of children in the group. To facilitate movement from this category the adult reinforces the child for sitting with the other children and for playing with toys similar to those of the other children. The adult encourages the normal population to share toys with the handicapped child, asks for toys from the handicapped child, and reinforces the handicapped child when he gives a toy to the normal peer. During this type of activity the child should be placed among the normal children, not on the fringes of the group. For instance, if there are five children sitting at a rectangular table, the child should not be placed at the end of the table but in a position where normal peers are on all sides.

*Source: Bailey, D.W. (Ed.). Ongoing Data Collection In The Classroom. Seattle WA: Western States Technical Assistance Resource, 1978.

6. Associative Play: The child plays with other children. The conversation concerns their common activity. There is a borrowing and loaning of play material, following one another with trains or wagons, sharing pencils, and paper. There are mild attempts to control which children may or may not play in the group. All the members engage in similar if not identical activity; there is not division of labor, and no organization of the activity of several individuals around any material goal or product. The conversation of the handicapped child with the other children tells us that his interest is primiarily in his association, not in his activity. To facilitate this activity the adult provides a setting where all normal peers are engaging with the handicapped peer, and reinforces the normal peers for conversation and sharing of objects with the handicapped child. The handicapped child is also reinforced for playing with the normal peers. During associative play, if the handicapped child steps out of the setting, the adult should direct the handicapped child to engage again in that activity and reinforce the child when he re-enters the group.

Handout 18

SOCIAL BEHAVIOR OBSERVATION FORM

Setting: Location (classroom, etc.) ______________________________

Activity (group instruction, free play, etc.) ______________________________

Child: ____________________ Observer: ____________ Date: __________ Time: _______ to _______ (10 minute period)

ACTIVITY CATEGORIES

*For every minute, observe first 10 seconds; record (tally). Observe last 10 seconds; record

Peers (List)	Unoccupied Behavior	Solitary Independent Play	Adult Directed Behavior	Onlooker	Parallel Activity	Associative Play
	_____%	_____%	_____%	_____%	_____%	_____%

*Twenty 10-second observations are carried out during a 10 minute period. To compute the percentage of time child engaged in each social behavior, the amount of time child engaged in each behavior is divided by the total amount of time in the observational sample:

$$\frac{\text{Number of Seconds}}{\text{Total Time Sample}} = \frac{\_\_\_\_\_\_\_\_}{\text{600 Seconds}} = \_\_\_\_\_\_\%$$

HANDOUT 19 - SELF-HELP SEQUENCING SHEET

Topic: Manages Independent Routines
Directions: Cut these apart
Arrange in Developmental Order

Understands and stays away from common dangers: may take care not to fall on stairs or from high places or may show that he knows danger of things, such as broken glass, busy street, strange animals.

Carries a tray

Carries breakable objects

Helps at household tasks (dusting, drying dishes)

Helps adults, putting his own toys away

When told, brings something from or takes something to someplace; is able to find the object from spoken instructions and carries out such orders as "bring it here" or "take it to mommy."

Fixes a bowl of dry cereal for himself includes getting bowl and cereal, pouring both cereal and milk into bowl

Able to keep "working" for at least 20 minutes with similar aged child in a single task, such as making buildings or roads with blocks, logs, sand, or mud, or rearranging a room or area for doll play, such as store, school, or house.

Helps with adult activities in house and garden

Able to fix a sandwich; must be able to get the right foods from refrigerator, cabinet, and/or breadbox and put them together in a sandwich

Makes effort to keep surroundings tidy

Puts toys away neatly when asked to do so; often must be asked more than once

Goes about house without needing to be watched constantly; may need occasional checking as to where he is, what he is doing

Carries water without spilling while walking

Knows difference between foods and things that cannot be eaten; may put something other than food in his mouth but does not chew and swallow it.

Puts toys away neatly in box

Performs simple errands

Often does household chores which do not need redoing by an adult (may do them in response to request)

HANDOUT 19 - continued

Topic: Toileting, Grooming, Washing
Directions: Cut these apart
Arrange in Developmental order

Indicates wet or soiled pants

Sits on potty or toilet without resistance.

Washes face well (except for ears) and dries without help

Cooperates in washing and drying hands

Knows which faucet is hot and cold

Washes hands and face using soap, with assistance

Dries hands and face after washing

Brushes teeth without assistance

Pulls pants down for toileting

Has no more than one toilet accident per month (includes waking and sleeping, both bladder and bowels)

Is usually dry after naps

Completely cares for self at toilet, including cleansing and dressing. Goes to toilet by self during the night

Adjusts water temperature

Toilet trained for bowel control (daytime)

Goes to toilet without help

Beginning to signal toilet needs by word or gesture

Washes face without assistance

Removes clothing for toileting (need not buckle, zip, or button)

Stays dry all night

Can brush or comb hair acceptably except for special occasions

HANDOUT 19 - continued

Topic: Feeding
Directions: Cut these apart
Arrange in developmental order

Discards bottle

Controls drooling

Lifts a cup to mouth and drinks with some help

Lifts cup to mouth and drinks unassisted

Sucking and swallowing are present

Feeds self using a fork and/or spoon and glass correctly

Picks up spoon by handle

Uses table knife for spreading

Gets a drink unassisted from fountain or sink

Feeds self with spoon (with some spilling)

Puts on own coat without assistance (need not be buttoned)

Sucks from a plastic straw

Unbuttons one or more buttons

Fixes bowl or dry cereal (gets bowl, cereal, and milk and pours cereal and milk into bowl)

Discriminates edible substances from inedible ones

Pours a drink

Uses napkins

Uses fork but may prefer spoon

Chews table foods

Feeds self cracker

Uses knife for cutting

Prepares sandwich including getting food and putting it together

HANDOUT 19 - continued

Topic: Dressing
Directions: Cut these apart
Arrange in developmental order

Removes shoes (may be untied)
Removes coat without help when buttons and zippers are undone
Dresses and undresses unassisted (tying shoes not included)
Assists with dressing by holding out arms for sleeves or foot for shoes
Puts on "pull-over" garments
Buttons medium sized buttons
Puts shoes on correct feet
Inserts belt in loops
Zips front non-separating zipper
Puts on "pull-up" garments
Unzips separating front zipper
Buttons one or more buttons
Can take off all clothing including pull-over
Unzips (non-separating) zipper
Zips front separating zipper
Buckles belt and shoes
Puts on boots
Pulls at clothing with hands
Pulls off socks
Pulls off hat
Tries to put on shoes
Puts on dress
Puts on shirt
Laces shoes
Puts on socks

HANDOUT 20 - FEEDING EXPERIENCE ANALYSIS GRID

	Removal of soft food from a spoon Applesauce	Drinking from a cup Water	Biting and Chewing a Butter Cookie	Chewing a Raisin
Normal movement patterns				
Effects of: 1. Head position a. flexion b. extension				
2. Lip retraction				
3. Jaw Thrust				
4. Tongue Movements a. tongue thrust b. tongue immobility with retraction				
5. Combines Pattern: head extension, lip retraction and tongue thrust				

HANDOUT 21 - ASSOCIATION FOR THE HELP OF RETARDED CHILDREN
FEEDING REMINDERS

Eating should be a pleasant experience for all children. A hungry child likes to eat and will enjoy his meals, if his surroundings are relaxed and pleasant. It is important that the parent talk to his baby during feedings, encouraging him to focus on mother's face and other faces in the environment.

The following points are to be remembered:

I. Positioning
  A. Firm supported upright position
  B. Good fitting chair
  C. Arms up if needs (on table)
  D. Feet supported on flat surface
  E. Head in erect midline position

II. Mid-line Feeding from Front
  A. Better socialization
  B. Better communication
  C. Enables child to see food as it approaches his mouth
  D. Feeder should be comfortable

III. Jaw Control
  A. From Front
    1. Thumb under bottom lip to open and close lips
    2. Middle finger stretched under chin just behind bone with some pressure to stop tongue protrusion.
  B. From Behind
    1. Index finder under botton lip to open and close lips
    2. Middle of finger under chin just behind bone with some pressure to stop tongue protrusion.
    3. Arm used to maintain good head position
    4. Thumb on cheek for added control
  C. Purpose of Jaw Control
    1. To prevent mouth from opening too far
    2. To keep lips closed
    3. To prevent tongue protrusion
    4. To normalize chewing and swallowing
    5. To inhibit the bite reflex during cup drinking

IV. Solid Foods
  A. Present at mid-line
  b. Put food on chewing surface to stimulate chew
  C. Promotes more normal oral sensations
  D. Chunks (cubes) of food the size of a thumbnail
  E. Encourage child to try new foods by continuing to reintroduce new or rejected foods in small amounts.

V. Spoon Feeding
  A. Introduce at mid-line
  B. Straight in and straight out with some downward pressure on tongue
  C. Wait for swallow and then repeat (may use jaw control)
  D. Thicker foods encurage more oral manipulation

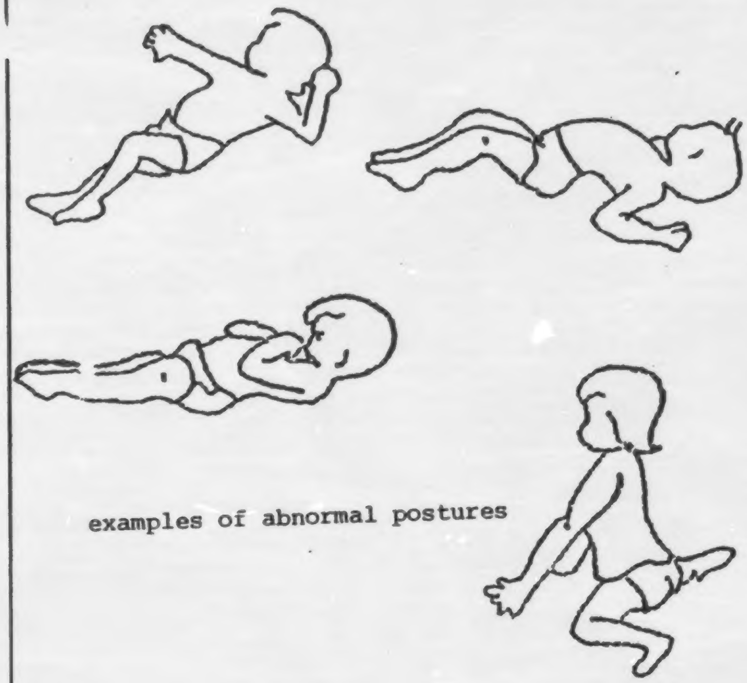
VI. Cup Drinking
   A. Use jaw control
   B. Cup is between lips, resting on bottom lip in front of teeth.
   C. Tilt only the cup
   D. Maintain lip closure on the cup
   E. Remove cup, wait for swallow and repeat
   F. Cup may be "cut-out" plastic, clear, or a shot glass

VII. Thick Liquid
   A. Easier to drink a thicker liquid
   B. The child must work harder to get it
   C. Strained baby food - fruits, nectars, milk shakes are excellent

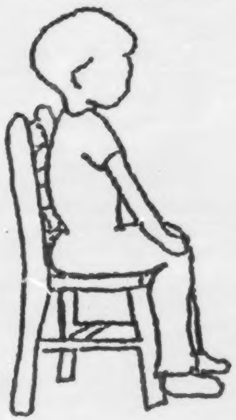
VIII. Gagging and Choking
   A. Gagging is normal, everyone does it
   B. Don't become anxious; child can usually clear gag by himself
   C. For choking, flex head and bend it down

HANDOUT 22 - POSITIONING TECHNIQUES

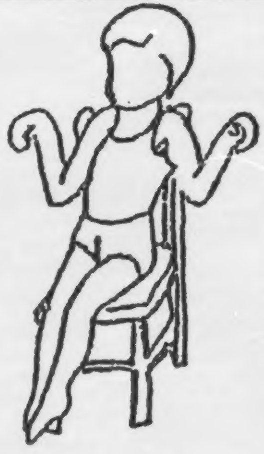
From: Handling The Young Cerebral Palsied Child At Home
by Nancie R. Finnie FCSP



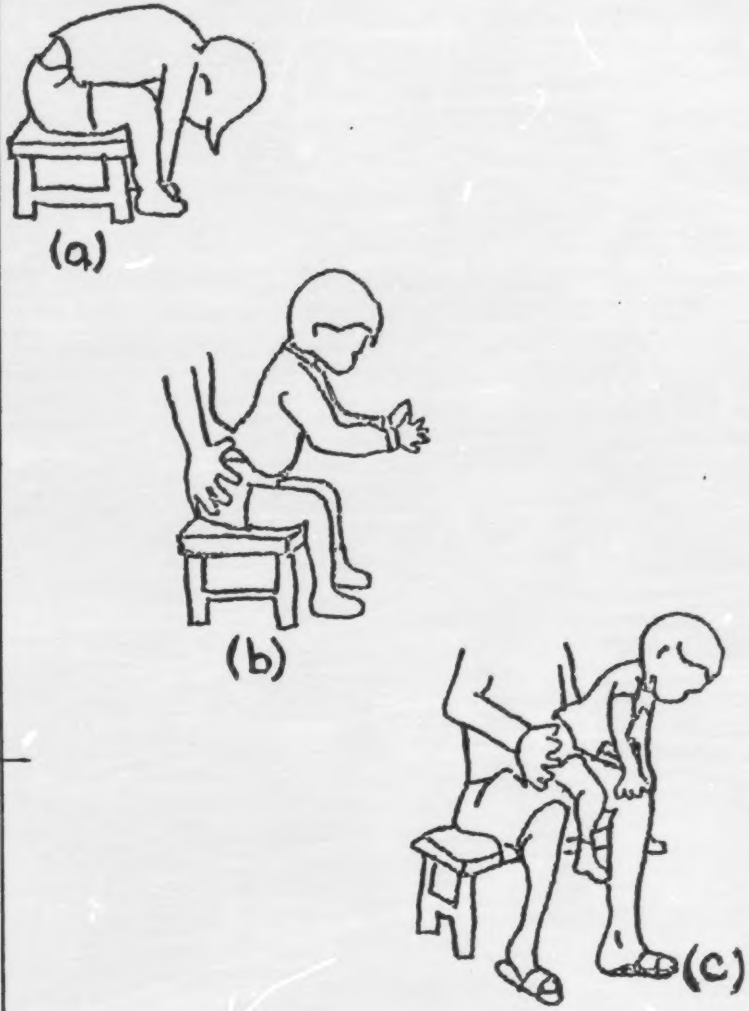
examples of abnormal postures



normal sitting position



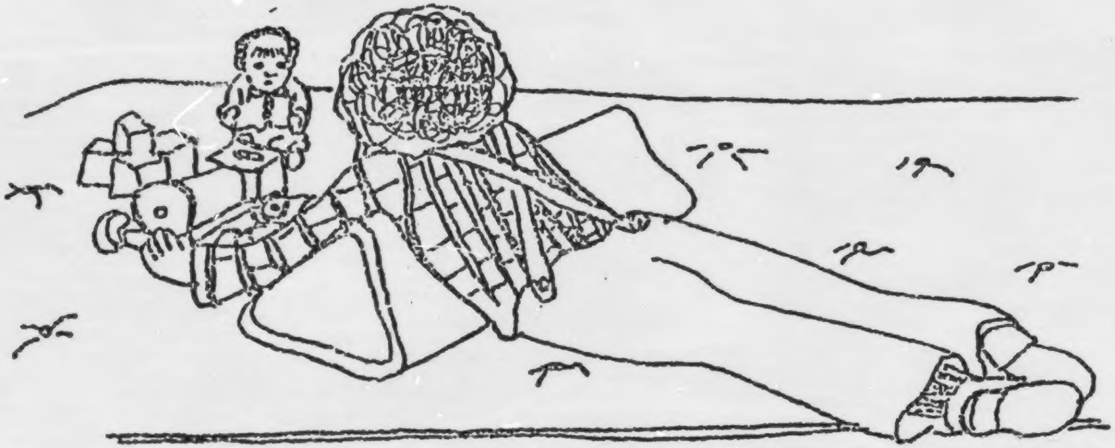
athetoid child
with spasticity



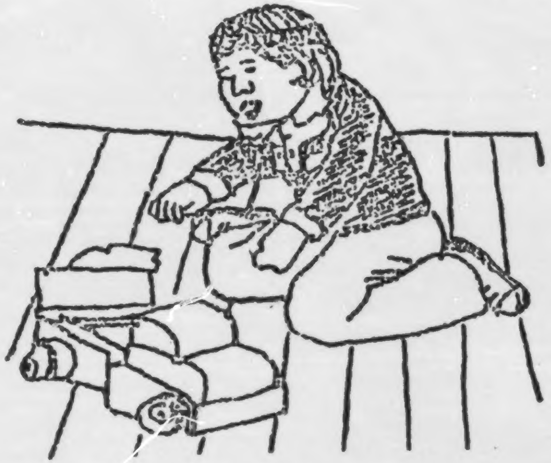
(a) floppy child sitting
(b) and (c) By placing hands firmly (pushing down) over lower back with thumbs at each side of spine gives the child a point of fixation and facilitates the raising of his head.

HANDOUT 22 (contd) - POSITIONING TECHNIQUES

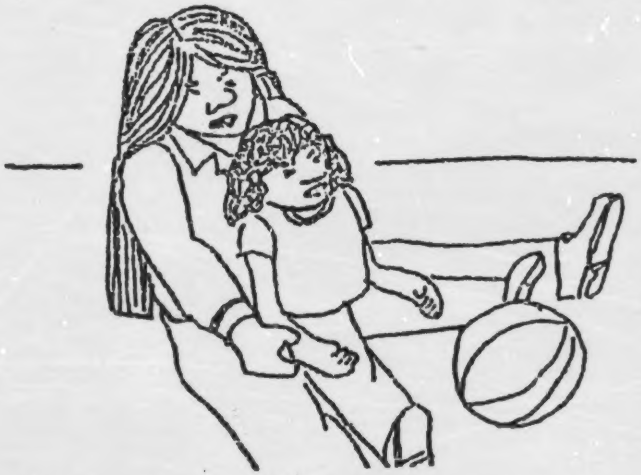
From: Mainstreaming Preschoolers: Children with Orthopedic Handicaps
by S.S. Kieran, F.P. Conner, as von Hippel and S.H. Jones



"Bolsters and wedges can be used to support the child in a prone position."

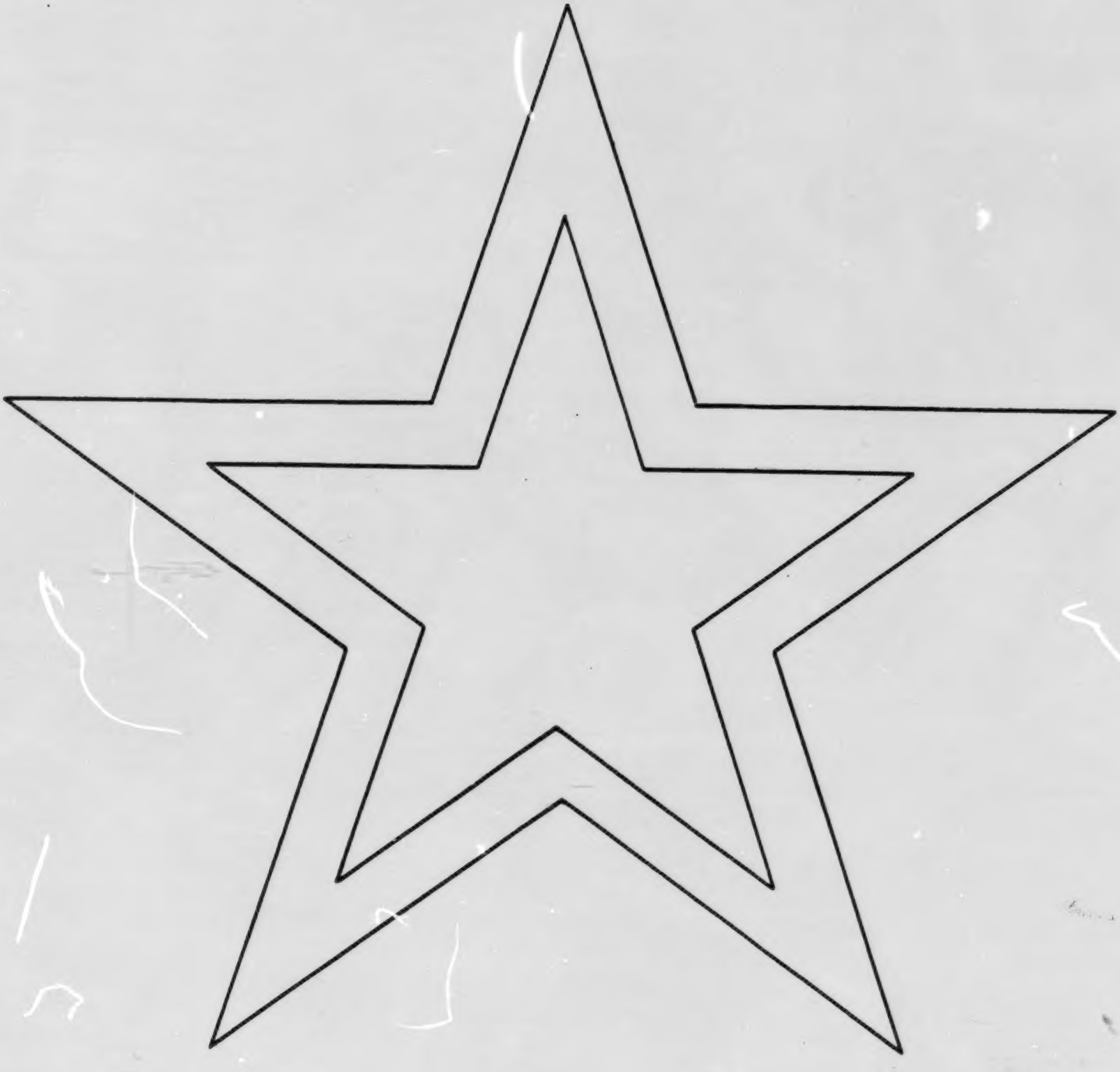


"Usually, orthopedically handicapped children should be discouraged from sitting in the "W" position."



Using your own body to give support and facilitation.

HANDOUT 23 - MIRROR WRITING



HANDOUT 24 - BLIND WORKER

APPLICATION FOR EMPLOYMENT

Personal

Name ______________________________ ____ Social Security No. ______________
LAST NAME First Name Middle Name

Present Address ____
No. Street City State Zip

Home telephone ______________ Office telephone ______________ Are you over the age of 18? ______________

Position(s) applied for ____

Minimum acceptable starting salary ______________ Who suggested you apply? ______________

Would you work full time? ______________ part time? ______________ What date will you be available? ______________

Person who should be notified in case of emergency ______________________________
Name

______________________________ ______________________________
Home Address Home Telephone

Education

Name and location of school, institution, or private instructor	Course or special field of study	Did you graduate?	Diploma or degrees

Last elementary and junior high school

High school and/or vocational training

College or university

Chief extracurricular activities and any special honors in high school or college ______________________________

____

Experience

Please give the record of your employment. Start with your present position and work back. Describe each position in one of the six numbered blocks; if there is not enough space, use extra sheets of paper to complete the record. If you were employed under a name different from your present one, please give the name then used on top of the appropriate box.

1. Present or most recent position

Exact title of position	Employment dates From To	Starting salary	Present or latest salary
Name of employer	Name and title of your immediate supervisor		Telephone
Address of employer	Reason for desiring a change		
Kind of business or organization and description of your work			

2. Former Position

Exact title of position	Employment dates From To	Starting salary	Final salary
Name of employer	Name and title of your immediate supervisor		Telephone
Address of employer	Reason for leaving		
Kind of business or organization and description of your work			

3. Former Position

Exact title of position	Employment dates From To	Starting salary	Final salary
Name of employer	Name and title of your immediate supervisor		Telephone
Address of employer	Reason for leaving		
Kind of business or organization and description of your work			

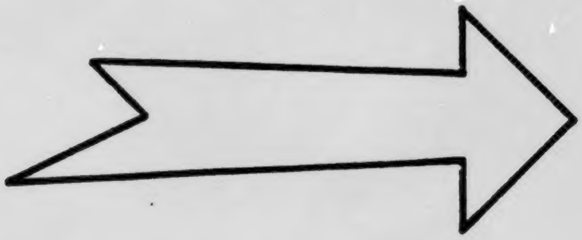
4. Former Position

Exact title of position	Employment dates From To	Starting salary	Final salary
Name of employer	Name and title of your immediate supervisor		Telephone
Address of employer	Reason for leaving		
Kind of business or organization and description of your work			

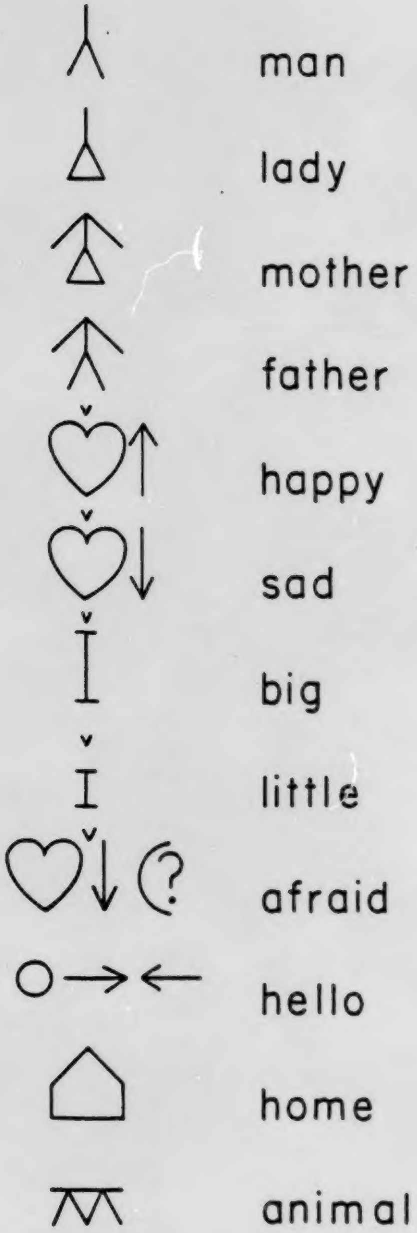
HANDOUT 25 - SYMBOLS AND COMMUNICATION TEST

Study for one minute without taking notes .

(Hint: Look for shape - meaning correspondence)



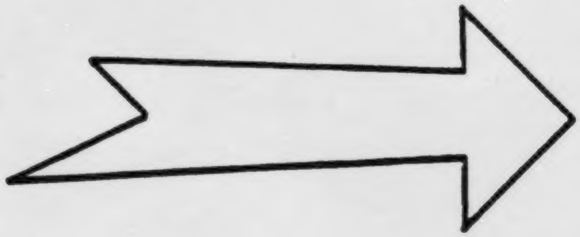
HANDOUT 25 - SYMBOLS AND COMMUNICATION (continued)

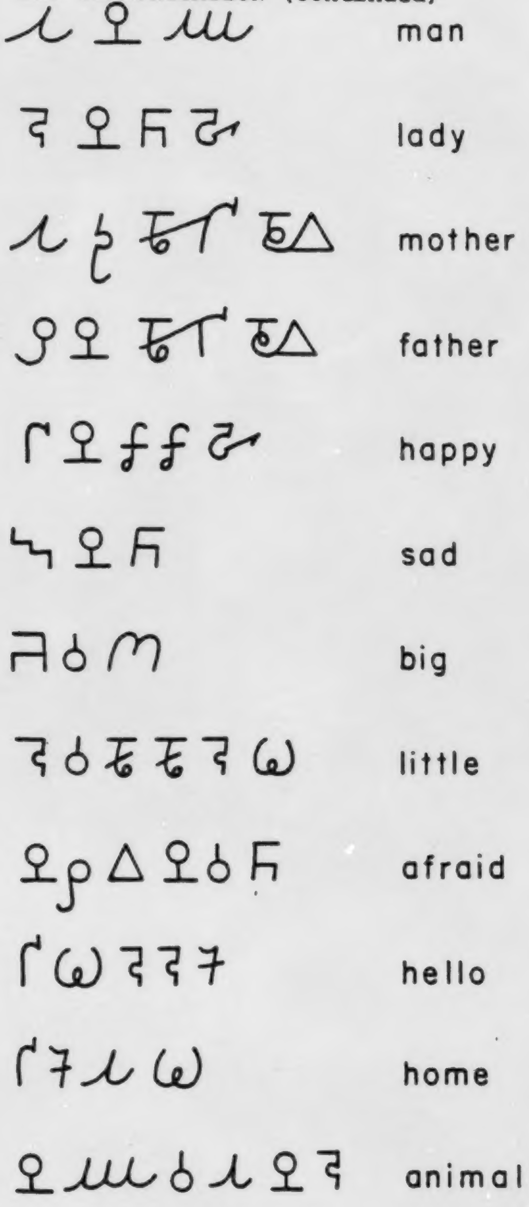

man
lady
mother
father
happy
sad
big
little
afraid
hello
home
animal

BLISS SYMBOLS

Study for one minute without taking notes.

(Hint: Look for sound - shape correspondence.)




man
lady
mother
father
happy
sad
big
little
afraid
hello
home
animal

SPENCE SYMBOLS

Now break for ten minutes of unrelated activity.

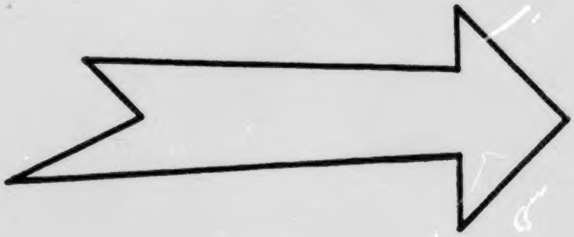
After ten minutes:

Allow yourself one minute.

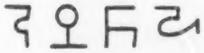
Write as many words as you can.

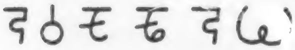
Do the easier ones first.

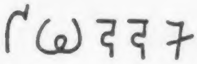
Your score is the total number correct.

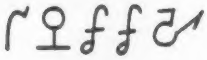


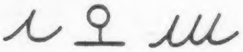
HANDOUT 25 - SYMBOLS AND COMMUNICATION (continued)

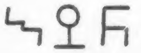
1. 

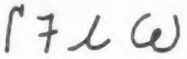
2. 

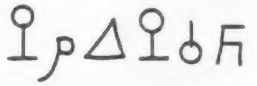
3. 

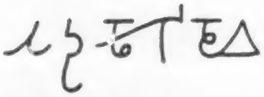
4. 

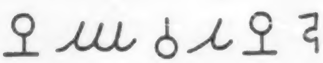
5. 

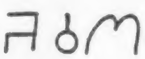
6. 

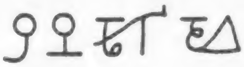
7. 

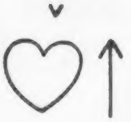
8. 

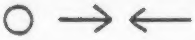
9. 

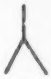
10. 

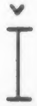
11. 

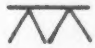
12. 

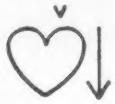
13. 

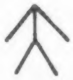
14. 

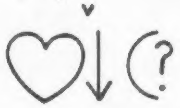
15. 

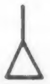
16. 

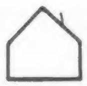
17. 

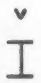
18. 

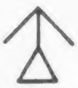
19. 

20. 

21. 

22. 

23. 

24. 

TEST PAGE

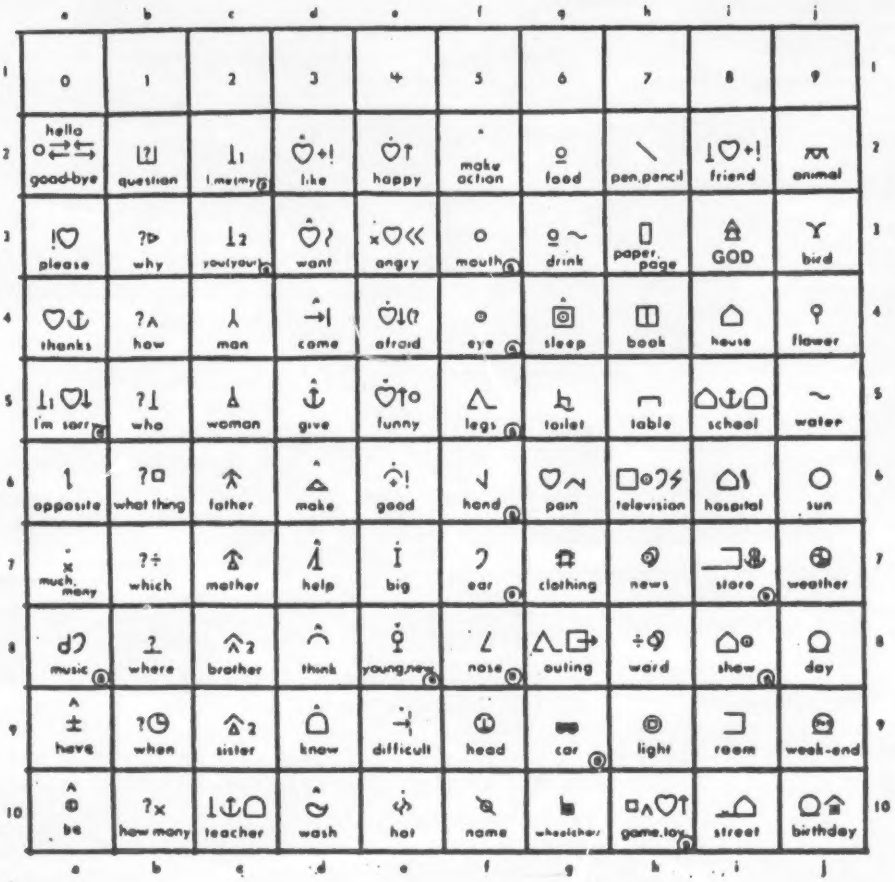
Handout 26

Blissymbolics called alternative to sign language

During World War II, Charles Bliss sat in a Nazi prison, and he began drawing symbols. His idea was to develop a system for international communication, and he hoped the system would contribute to world peace.

Thirty-five years, 3,000 symbols, and several wars later, the original idea is at least partially valid. The inventor of "Blissymbolics" also created a system of communication for severely disabled persons, including children who are not quick in learning conventional language.

Blissymbolics is described as an alternative to sign language for those who cannot learn finger signs or because of a disability, such as cerebral palsy, might find it hard to execute the signs.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friend
animal
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day
have
when
sister
know
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head
car
light
room
week-end
be
how many
teacher
wash
hot
name
wheelchair
game, toy
street
birthday

Some symbols depict relationships and feelings. Symbols can be combined for different meanings (for example, "building", "giving," and "knowledge" combine to make the symbol for school). And some symbols have a range of meanings, depending upon the context ("make-believe", pretend," "false").

The Ontario Crippled Children's Center in Toronto, looking for a way of helping disabled communicate, began using Blissymbolics. Later, there was formed the Blissymbolics Communication Foundation in Toronto. Bliss, who is a chemical engineer, gave exclusive rights for his symbols to the foundation.

Since Blissymolics can be combined to form new meanings, it provides children with a wide range of words while using a small number of symbols. Within a few months, children who are capable of gross hand pointing are at work on a 100-symbol vocabulary.

Barbara Kates and Shirley McNaughton report that at the end of three years, the following observations can be made:

1. Symbols appear effective both as a supplement and as a substitute for speech.
2. Symbol use continued to encourage speech.
3. It became possible to identify levels of symbol development (recognizing symbols, acquiring fluency, and adapting symbols to meet specific needs).

DDO NEWSLETTER July-Aug 1977

4. Symbols enabled the child to communicate with a wide range of people.
5. Use of symbols enabled them to take part in classroom activities directed toward developing skills in logical thinking, classifying, and vocabulary development.
6. Concentrated instruction seemed necessary at first, and once they made the breakthrough, they moved quickly.
7. Skills were readily transferred to the reading of words.
8. The use of symbols as a child's means of response made it possible to improve assessment in hearing, language, psychology, and education.
9. As children interacted more with their environment, they showed greater self-confidence and developed their individuality.
10. There are two styles of communicating: For the child who can point, greater independence and more regular syntax patterns could be expected. Those who must use equipment are limited in the number of symbols available and speed of producing them, and they depend more on supportive eye and body movements and upon the persons with whom they are communicating.

One of the organizations in the United States making use of Blissymbolics is Oakdale Center for Developmental Disabilities, Lapeer, Mich, where four speech pathologists and four activity training aides are teaching the system to about 40 residents. The Center's newsletter, Spectrum, reports that symbols taught there are always used with words and are adapted to the individual.

Further information on this communication system can be obtained from Blissymbolics Communication Foundation, 862 Eglinton Ave. East, Toronto, Canada M4G 2L1.

HANDOUT 27 - COMMUNICATION BOARDS: HELP FOR THE CHILD UNABLE TO TALK

by Sharon Von Bruns-Connolly and Howard C. Shane

Speaking is the most common way to communicate. Most of us tend to think of speech as the only means of expressing ideas, needs, and wants, and at first it may be difficult to consider using any other.

But for some children, speaking is not an effective way of communicating. For them, trying to converse with others through speech is a frustrating and discouraging experience. It is also difficult for the people around them - family, friends and teachers - because they feel helpless knowing that the children have thoughts and feelings they want to express, but cannot.

Finding other ways for such children to convey what they want to say is of the utmost importance. If speaking is not now a useful way of communicating for your child, the solution may be a "communication board."

Many children who cannot communicate orally use communication boards. One can be planned to fit your child's needs and abilities - not just in the present, but also as they change over time. For this reason, what communication boards look like and how they are used may vary a great deal. The principal, basic points behind their use are simple. Your child or another person points to a picture, a printed word, a special symbol or several letters of the alphabet, according to some rules chosen ahead of time. Each of these methods can be used to communicate the same meaning. Your child may point to a picture of a glass of milk, say, "milk" or write the word "milk". In all these cases he conveys the same idea: "I want some milk". The specific method that is best to use will depend on your child's abilities and level of development.

A communication board can provide your child with access to two-way communication and with a way of expressing himself spontaneously. It can give him experience with language at the age when it is critical, and thus help him progress toward the use of more and more complex language.

At the same time, the communication experience a board provides improves your child's abilities in social interactions; it also increases his skill in organizing his thoughts and ideas. Perhaps even more important, it prevents the feelings of stress and failure that can arise when speech is unwisely insisted on; such feelings often result in a decrease in the child's willingness or ability to communicate.

Communication boards may in fact stimulate some children with vocal potential to speak more. The reasons for this effect are not clear. Speaking may become easier for the child when he is no longer under pressure and is more relaxed. In fact a communication board might be considered a form of indirect speech therapy because it may increase the amount of speaking a child does. Programs are sometimes developed that use communication boards along with speaking. In general children are more eager to communicate when it becomes easier and more enjoyable for them to do so.

When a communication board is being designed for your child, his cognitive abilities, educational skills, physical abilities and communication needs are taken into account. These considerations determine the type of communication board that is best for him, the kind of items included in it and the way these items are arranged.

When a communication board is carefully matched to your child's specific needs, it is likely to be appropriate, usable and acceptable to him. And he will have the best chance of having successful communication experiences.

TYPES OF COMMUNICATION BOARDS

Communication boards range from relatively simple nonelectric boards to more sophisticated electric models. Systems of cards, a notebook, boards with replaceable content sheets and trays attached to a wheelchair are simple and inexpensive and are usually the most desirable formats.

Some types require the aid of a second person. Others can be used independently. Certain models involve finger-pointing, others use aided pointing (head pointer, hand extension or similar aids) and still others use a system of flashing lights. The choice of a method depends on the physical abilities of the communicator. Some boards are available commercially, but most are designed and constructed for specific individuals.

THE CONTENT OF COMMUNICATION BOARDS

The content of the board is very important in the child's development of his language and communication abilities. The content of the board should represent the items and concepts he will need in different situations. The content must be appropriate to his educational ability and at the same time should present the kind of challenge that encourages learning.

The board may include one or more types of items. Picture boards using photographs or line drawings are designed for children who do not read yet. The name of the object is often printed underneath each picture. As the child learns to recognize the printed word by itself, without the picture, he builds up a larger and larger sight vocabulary. As the child's abilities increase, beginning picture boards can be expanded to include both more items and the more abstract items that are important in social interactions.

Boards with words and everyday, functional phrases are introduced once the child has begun to develop a sight vocabulary. Two types of words should be on these boards: those the child uses frequently and those used most often by all communicators. An alphabet and a number line can be included so the child can spell out words not already on his board.

Sometimes specialized symbols are used instead of printed words for nonreaders. As the child's language skills continue to develop boards are set up to allow him to construct complete and grammatical sentences. More and more words may be added. The important point is that the child begins using a board that is on a level with his abilities. He then moves to more sophisitcated boards at his communication abilities change and develop.

THE PHYSICAL LAYOUT OF COMMUNICATION BOARDS

Two considerations determine the layout of the communication board. First, where the board is placed and how the material is set up- it should be appropriate to the child's range of movement and coordination. Second, the material should be organized in specific ways that help him develop more complex kinds of communication. The board is designed, then, to allow the child to use it fully and to encourage growth in organizing thought and developing language.

ONE EXAMPLE OF A COMMUNICATION BOARD

The program set up for Chris, an eight-year-old boy who has cerebral palsy and uses a wheelchair, indicates how communication boards are actually used and how they help a child's language abilities to develop.

At first Chris's communication was limited to a few gestures and unintelligible vocal sounds. His family had difficulty understanding what he was trying to express, and this upset him. Chris understood what was said to him, and his intellectual ability seemed normal. He had no reading skills other than simple recognition of the letters of the alphabet.

It was decided that Chris wuld benefit greatly from using a communication board. A board with 18 labeled pictures of familiar objects and people (for instance, cups, television, Mommy, truck), needs (like toilet, drink, food), and concepts (up, down, big, little, more and so on) was constructed and attached to his wheelchair.

The therapist working with Chris began by pointing to each picture, saying its name aloud, and using it in a variety of sentences - "This is the truck. The truck is red. The truck can go fast."

The he repeated the procedures, this time having Chris point to the picture and attempt to say its name after him. Once the therapist was sure Chris understood what each picture represented, he asked for a picture at random: "Show me the truck." Chris pointed to the appropriate one. Chris then had a chance to point to a picture and decide whether the therapist could name it correctly.

Chris began using his board at school and at home. He was hugged and praised when he used it to communicate what he wanted. If he pointed to the picture of a truck, his mother said, "That is the truck. You want the truck", as she pointed to it. Then she gave Chris the toy truck, telling him what a good job he had done.

Chris very quickly began using two pictures to express himself; "No television." "More food." Soon he needed some grammatical markers and a much larger vocabulary to choose from. A number of picture and word cards were made for him, each with a set of related objects or words (a card with people, one with toys, one with descriptive words and one with verbs and verb endings.) The name of the objects from the first board were included, but without the accompanying pictures.

Chris began using his new picture and word board, and the same procedure was followed. Chris was introduced to the pictured concepts and written words, practiced them, and then began using them in everyday communication.

His family spoke sentences aloud. They expanded what Chris had communicated by pointing out and saying aloud a more complicated sentence. For example, Chris's "Truck goes" was expanded by his older brother, who pointed to it and said, "The truck goes there." Social phrases ("Yes, please." "I'm fine, thank you." "How are you?") and certain frequently used phrases ("I have a..." "I am a ..." "May I have a...?") were gradually introduced. More pictures were removed, leaving only their printed names.

Chris is now learningwritten words without accompanying pictures, and he can produce four and five-word sentences on his own. His reading skills are increasing to the point where he will soon begin using a more complex board.

USING A COMMUNICATION BOARD WITH YOUR CHILD

A communication board may be the best way for your child to become an effective communicator. A well-designed board will help him to initiate communication with others and will stimulate his intellectual and social growth. Your part as parents is an important one, since you will be using the board consistently with your child. In addition you will serve both as daily models of its use and as sources of encouragement and incentive for him as he uses it.

HANDOUT 28 - BARRIERS CHECKLIST*

A barrier is something that makes it very difficult or impossible for a disabled person to get into or around a building. Is your school barrier free? Use this checklist to find out. And if your school does not do very well on the checklist, don't be too surpised. Most buildings have barriers. And barriers can be changed.

	Barrier-Free	
If the main entrance to the school has a ramp it is barrier free. If it has stairs, and no ramp, it has a barrier.	Yes	No
Are the door knobs of all main doors 3 feets from the ground so that people in wheelchairs can reach them?	Yes	No
Do the hallways have handrails to help people walk? No handrails is a barrier for some people.	Yes	No
Parking Spaces: Are there parking spaces reserved for disabled people? Are they near the entrance of the building? Are they 12 feet wide? Are there at least 2 out of every 100 spaces reserved for people who have disabilities?	Yes	No
Are there curb cuts so that people in wheelchairs, or people with baby carriages or shopping carts can pass easily?	Yes	No
Are there tactile markings (can be felt by touch) cut in the sidewalk to warn people who are blind?	Yes	No
If your school has more than one floor, does it have an elevator? (Skip this question if your school is one floor).	Yes	No
Does the elevator have braille markers for the floor buttons? (Skip this question sif your school is one floor).	Yes	No
Does the elevator have light and bell signals to help people who are blind or deaf to know when the elevator is ready? (Skip this question if your school is one floor).	Yes	No
Are the doorways to all bathrooms at least 33 inches wide?	Yes	No
Are your sinks low enough? Get a chair and see if you can reach the sink while you're sitting in the chair. If not, then the sinks will probably be unusable for people in wheelchairs.	Yes	No
Are the telephones in the building accessible? Use the same test as for the sinks. How many inches should they be lowered?	Yes	No
Are the fire alarms low enough for people in wheelchairs?	Yes	No
Are there grab bars in the bathroom stalls so that people can lift themselves from a wheelchair to the toilet and back again?	Yes	No

BARRIERS CHECKLIST - continued

Are the windows 24 inches or 28 inches from the floor so that short people and people in wheelchairs can see out?	Yes	No
Are the aisles in the classroom at least 32 inches wide so that people in wheelchairs, or on crutches, or with canes or walkers, can get around easily?	Yes	No
Are there flashing lights for fire alarms so that deaf students will know if there's a fire?	Yes	No
Are there picture signs to show the purpose of each room so that people who cannot read will know where to go?	Yes	No

Count up the number of Yes answers. Total Yes answers ____________________

Count up the number of No answers. Total No answers ____________________

Here is how to figure out whether your school gets a passing grade or not:

$$\frac{\text{Multiply Number of Yes Anwers x 100}}{18} = \_\_\_\_\_\_\_\_\%$$

70% is a passing score.

*Source: Barnes, E., Berrigan, C., & Biklen, D. What's The Difference. Syracuse, NY: Human Policy Press, 1978, pp. 80-83. Reprinted with Permission.

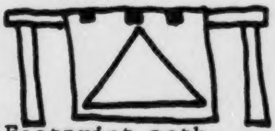
HANDOUT 29 - DIRECTIONS

ACTIVITY 2:

Designing Classroom Environments

The purpose of this exercise is to actively take part in planning the physical environment of a classroom based on the needs of ALL children. You are to use the packet of felt forms and flannelboard to create a floor plan for children with a variety of needs. Assume that in your class of 18 children, ranging in age from 3 to 6 years, there are a wide range of individual differences in skills. One child has mild motor delays and has a lot of difficulty following directions. Another child has severe motor and self-care difficulties and is socially withdrawn. A third child requires use of a wheel chair, cannot feed herself or express herself verbally, and is allergic to all dairy products. The other children in the class exhibit typical variations in development. How can the classroom environment best accommodate all these children?

HANDOUT 30 - OBSTACLE COURSE

Developmental Domain	Object/Activity	Action Adaptions
	Table with shape cutout attached 	
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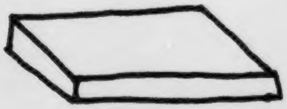
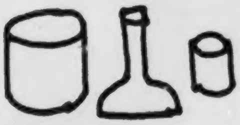
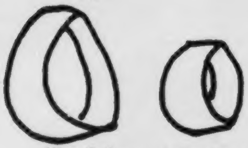
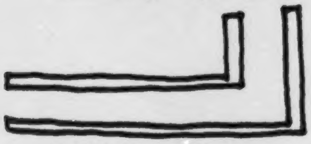
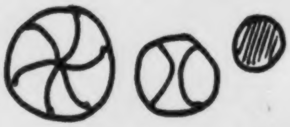
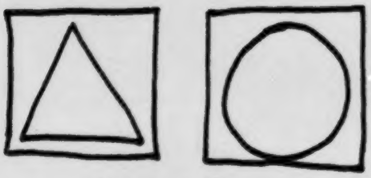
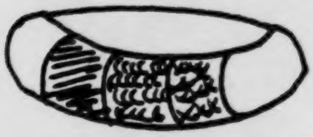
	Mat 	
	Containers & objects to put in containers 	
	Hoops 	
	Masking tape path 	
	Different balls 	
	Play with balls	

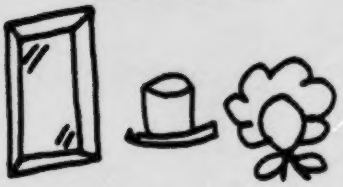
Large shapes



Inner tubes



Dramatic play items (could also add a mirror)



Parachute

HANDOUT 31 - EASILY CONSTRUCTED ADAPTIVE AND ASSISTIVE EQUIPMENT

Rebecca F. Dubose and Kristine Deni

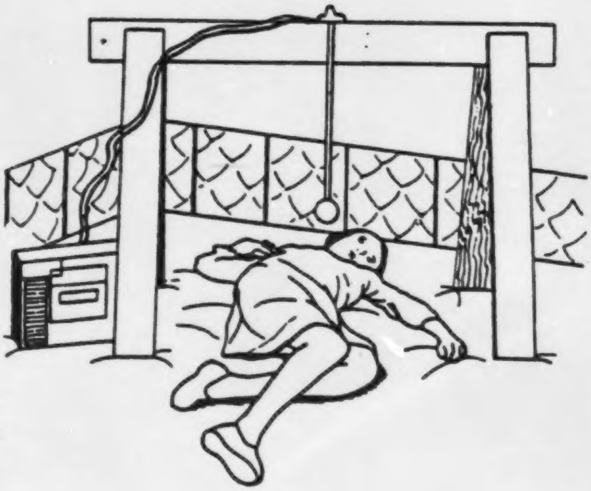
With the advent of Public Law 94-142, the Education for All Handicapped Children Act of 1975, the number of physically impaired children entering public schools has increased dramatically. The majority of these children have severe impairments that made public school education a less likely possibility prior to 1975. Their attendance in public schools has created a demand for services that previously were in short supply. In recent years, numerous personnel preparations have begun training teachers for this target population. A cadre an ancillary personnel, including occupational and physical therapists, are now full time employees in public schools. A major problem facing school administrators and teachers is the cost of equipment and materials. These support systems are essential if severely physically handicapped children are to spend their days in different environments. The equipment presented in this article was designed, constructed or adapted, and used in classroom of severely involved, physically handicapped children at the Harris Hillman School in Nashville, Tennessee. A very cooperative and interested maintenance employee helped the teacher construct this very useful assistive equipment. The cost of this equipment was minimal as most of the basic materials were donated or secured through low budget shopping.

The equipment presented does not represent all that is needed to outfit a classroom, however, it served to meet individual child needs and supplemented what was available within the system. In each case, the purpose for the piece, the steps in construction, and the uses or variations are noted. If possible, we recommend that a doctor, physical therapist, or occupational therapist approve the adaptive equipment.

RING PULL TOY

Purpose

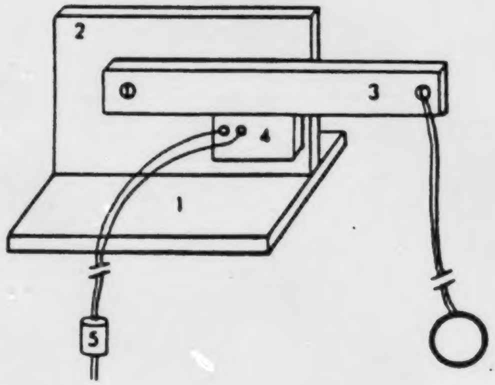
- * To provide a sensitive, easy to operate, general switch that can activate various reactive devices such as a tape recorder or slide projector.
- * To provide practice in reach, grasp and pull.
- * To provide practice in means end relationships.



Construction

1. Purchase a microswitch (4) from an electronics supply store.
2. Cut three pieces of either wood, plexiglass, or metal in the following sizes: #1-2 inches by 3 inches; #2-2 inches by 3 inches; #3-½ inch by 4 inches. All will be cut from ½ inch materials. These will make the basic hinged arm. #1 will be the base. #2 will be attached at right angles to the side of the base using glue or nuts and bolts. #3 (the arm) will be attached to #2 with a nut and bolt.

3. The switch will be mounted on the under side of the arm. Attach a rope and ring to the free end of the arm. When the arm is pulled down, the switch will close.
4. Use 2 channel speaker wire as a lead that terminates in a subminiature phone plug (#5) and fits into the remote jack of a common tape recorder.



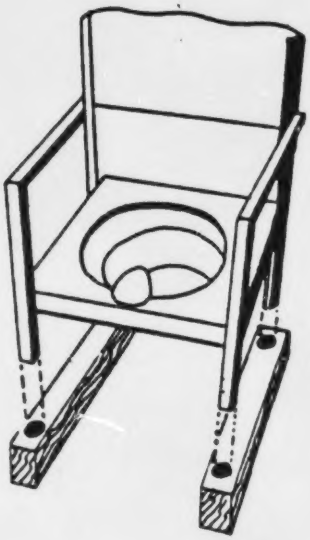
Uses or Variations

1. The switch can be mounted on the top of a sawhorse with the rope and ring dangling down. The child can be positioned in sidelying or supine position under the sawhorse, or sitting in a chair or flexion box or corner with the ring at the midline, or preferred hand.
2. The size of the ring can be varied as the child's ability develops.
3. Because this is basically an on-off, general switching function, the switch can be made to activate a variety of stimuli. For visually impaired children, it can turn on a tape recorder that will play as long as the child holds the ring down. For a deaf child, the switch could activate a colored light or mobile. It could also be hooked up to a slide projector that changes slides every 15 seconds When the child pulls down the ring, the light will shine and display the slide as long as the ring is held down.

POTTY CHAIR STILTS

Purpose

* To raise the height of commercially available portable potty chair.



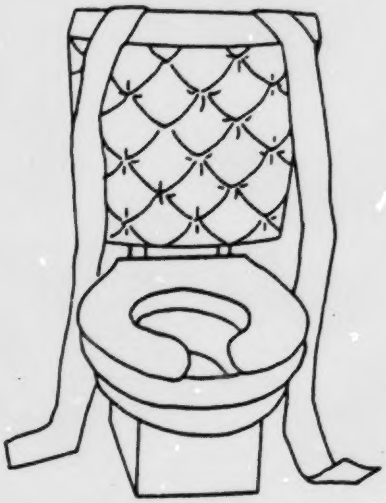
Construction

1. Cut two pieces from a 2 inch by 2 inch piece of wood so that the pieces are 1 inch longer on each side than the base of the potty chair.
2. Cut ½ inch plywood into a rectangle the same length as the supports cut in Step 1, and 2 inches wider.
3. Attach the plywood and the bases as pictured.
4. Drill holes for the legs of the potty chair with a 1 inch drill bit.
5. The chair can now be lifted in and out of the holes.

Uses or Variations

1. For a child with scoliosis who tends to "fall over" the side of the potty, adapt in this manner:
   a. Attach a support to the base that will hold the child upright. Make sure to include the cut out so the tray can still be attached to the arm of the potty seat.
   b. Construct the side support from plexiglass so as not to obstruct the child's view of the classroom.
2. The chair can be lifted out of the supports so that it can be used with a shorter child.
3. The base can also be increased in height for use with a taller child.

PADDED POTTY BACK



Purpose

* To adapt an institutional toilet so that it provides back support.

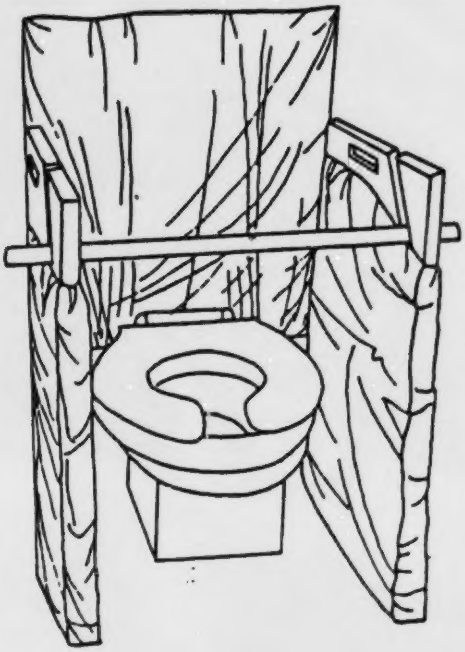
Construction

1. Acquire a discarded padded footstool. Remove the screw-in legs.
2. Nail or staple a tie to the underside of the stool pad. (One or two ties).
3. Tie these around the back pipe of the toilet so the padding is against the child's back.

Uses or Variations

1. You can use this as described above for a child who has sitting balance, but has a tendency to lean back.
2. For the child who has variable sitting balance, ties can be attached to the cardboard bottom of the stool and tied around the child's trunk.

TOILET FRAME



Purpose

* To adapt an installed, institutional toilet so that it will provide back and trunk support and a bar to hold on to.

Construction

1. Back panel: Measure the height and width of the toilet. Cut plywood 3 inches wider than the commode and as high as the top of the child's head. Make a cut out in the bottom of the plywood side enough and high enough so the piece can be slipped over the back of the seat and will rest on the floor.
2. Side panels: Cut the side panels long enought to extend to the child's knees and high enough to provide upper trunk and shoulder support.

3. Attach the sides and back with L braces (corner braces).
4. Dowel: Cut out a groove for the dowel in the side panels. The groove will slant down and away from the child's body. Cut the dowel so it has 5 inches to spare on each side of the side panel.
5. Make handholds in each side panel so the frame can be easily lifted off and transferred to another potty.
6. Pad the sides, back, and cover with vinyl. Be sure to cover all the raw edges of the wood so the child is not scratched when being lifted in and out of frame.

Uses of Variations

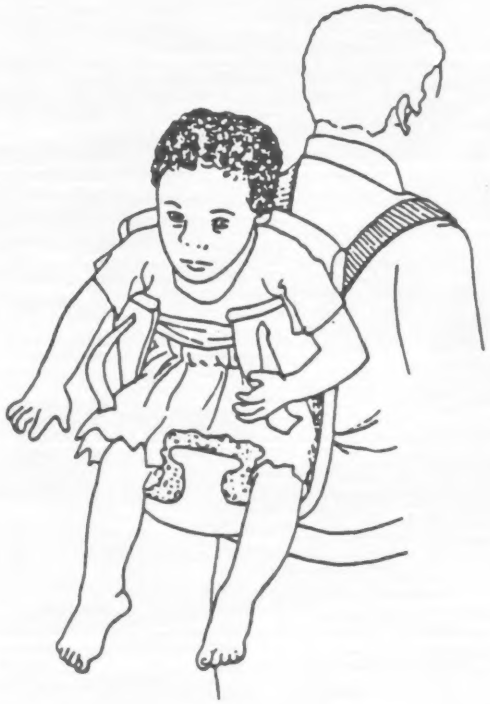
1. The dowel is used to replace ties around the child's trunk. An added advantage is that the child has an opportunity to develop his or her grasp and upper trunk balance.
2. If the child is unstable in the frame, however, ties can be attached to the wooden back panel.
3. Head pieces and scoliosis pads can be easily added if necessary.

BACKPACK

Purpose

* To provide proper positioning along with vestibular stimulation.

Construction



1. Cut an ordinary large plastic container, such as a bucket or waste basket, leaving a space just wide enough for the child's body to fit through, and leaving a piece of plastic that will serve as an abductor.
2. The child's arms can be either inside or outside the plastic depending upon whether the child tends to keep his or her arms tight and close to the body (and, therefore, should be brought out) or whether the child tends to flail them about (in which case you would want them inside the pack). If the child's arms are to be on the outside, make cutouts for underarm.
3. Line the bottom and back of the bucket with foam.
4. Cover the edges with rubber tubing to prevent chafing.
5. Attach a restraint for the child by making two slits in the back and threading through a piece of webbing that closes with either velcro or a buckle.
6. Attach the adult's shoulder straps by cutting two slits for each strap in the back of the pack. Thread the strap through. Sew one end closed around the clasp and thread the free end through the other half of the clasp. Allow enough strap for adjustment.

7. Glue two thick strips of foam to the outside of the straps to prevent the pack from "rolling" on the adult's back.

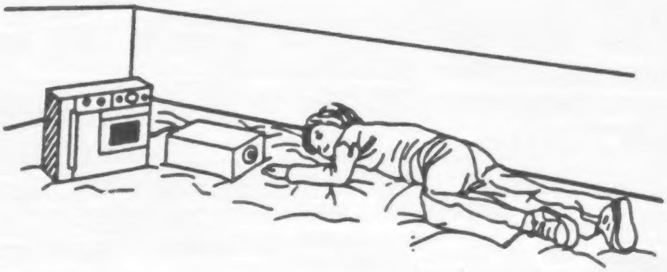
Uses or Variations

1. The hard plastic provides a firm base for the child's bottom with no sagging.
2. For children who are fearful of movement through space, carry the child about for short periods, and gradually increase the time.
3. This insert can be free standing. Therefore, when you have reached one destination, you can place the child on a chair while still in the pack, or you can use the backpack as an insert in a relaxation or Bobby Mac chair or car seat.

PUSHBUTTON

Purpose

* To provide a sensitive, wireless, and portable auditory feedback toy foruse in eye-hand coordination activities.
* To provide a wireless (portable) signalling device.



Construction

1. Gather the following items from a hardware or radio parts store: doorbell buzzer, metal or plastic box that will snugly hold the battery and sounding device.
2. Cut a hole in the box for wire the connect the button and the battery.
3. Connect the wires and seal the box.

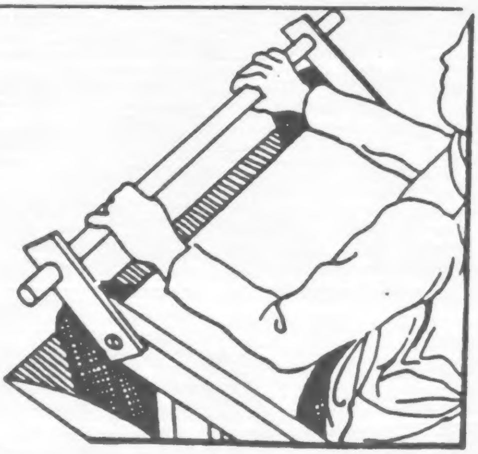
Uses or Variations

1. If the child is unable to push the small button, remove the outer casing from the doorbell and glue a large plastic or wooden circle to the original button. Paint it a bright color.
2. Mount the device permanently to the child's tray or desk. The child can then push the button to signal bathroom or other needs.
3. For the child jsut developing reaching skills, place the child in a sidelying position, and place the button ½ inch away from his or her fingertips. Gradually increase the distance from the fingertips.
4. Attach other stimuli to the button rather than the buzzer (i.e., lights, music).

DOWEL RODS

Purpose

* To keep toys on the child's tray so he or she can freely manipulate the toys without concern that they may drop to the floor.
* To provide stability while the chair is in motion by giving the child something to grasp.



* To provide stability while reaching or self feeding by giving the child's free hand something stable to grasp.

Construction

1. Cut out plywood dowel supports. They will be approximately 1 inch by 3 inches.
2. Drill holes the size of the dowel in the supports.
3. Mount the supports on the sides of the child's tray.
4. Slip the dowel into place.
5. Drill a hole in each end of the dowel just to the outside of the support.
6. Drop a bolt in the hole to keep the dowel from slipping off.
7. Attach the bolt to the support with a small chain.

Uses or Variations

1. If the child uses a wooden tray, holes may be drilled in the tray at various points. Short 4 inch by 6 inch pieces of dowel can then be placed in the holes perpendicular to the tray.
2. Placement of the dowels can be easily changed to accommodate different activities (handwriting, feeding, toothbrushing.)

CUT AWAY CUP

Purpose

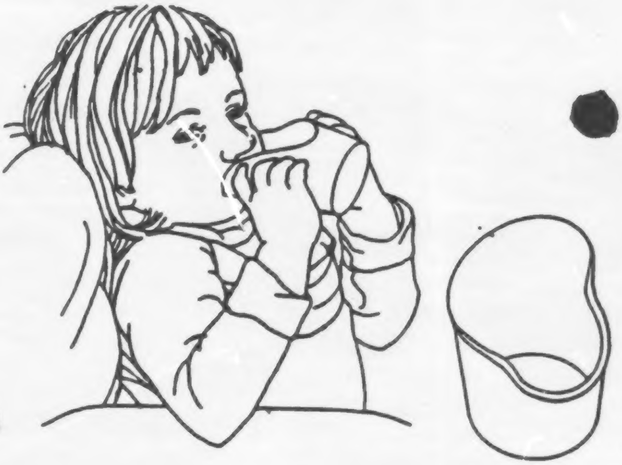
* To free eyes and nose from pressure and obstruction by the cup edge.

Construction

1. Any hard or soft plastic cup can be adapted.
2. Simply cut the desired opening (square or triangle shape) into the cup edge.

Uses or Variations

1. This adapted cup allows the person giving the child a drink to see the action of the child's mouth and to see the amount of liquid being presented to the child at each tip of the cup.
2. The child can drink without hitting his or her nose on the side of the cup.



SIDELYER

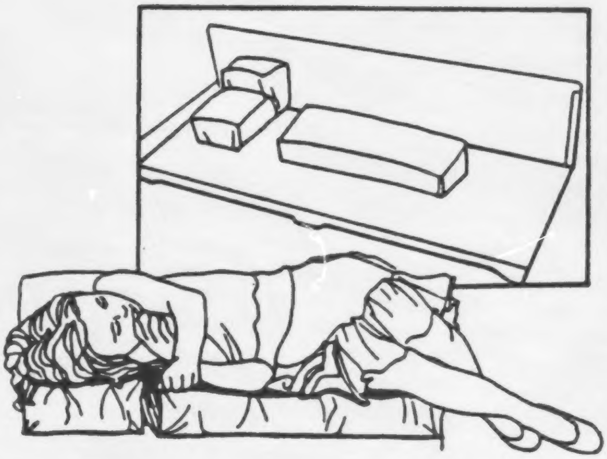
Purpose

* To provide comfortable and secure sidelying position.
* To bring hands together at the midline.
* To provide maxiumum eye contact with hands.
* To facilitate fine motor manipulations.

This idea has been adapted from one presented at the Blythdale Workshop in Chattanooga, Tennessee.

Construction

1. Measure child's height and add approximately 8 inches to accommodate growth.
2. Cut a base about 18 inches wide, and as long as above. Cut the back about 14 inches wide. Pad and cover with vinyl. Attach back to base with L braces.
3. Cut foam for trunk support. It should measure from the child's underarm to just above mid thigh. Cover with vinyl. Attach to base with velcro so that the pad can be moved in and out.
4. Cut head piece out of foam either as one solid piece or as two rectangles taped together. The small piece behind the head is intended to prevent the child from throwing his or her head back into extension. Cover with vinyl. Attach velcro loop to both ends of base of sidelyer at different levels. Attach velcro hook to bottom of head piece. This will allow head piece to be moved so child can lie on either side.



Uses or Variations

1. Alternate head piece placement each day so child lies on both side.
2. Position child in this when class is involved in floor activities.
3. Make baseboard wide enough so another child can be positioned facing first child. Good for social interaction.
4. Parents can use a similar model at home for times when child would otherwise be positioned on his or her back.
5. Position reactive toys (such as buzzer box and ring pull) just beyond the child's reach. A good, independent eye-hand coordination activity.
6. For the child with severe hip extension, slip a 3 inch wide cloth tie between base and back peices so that it fits around back of sidelyer and child's hips. Secure with velcro.

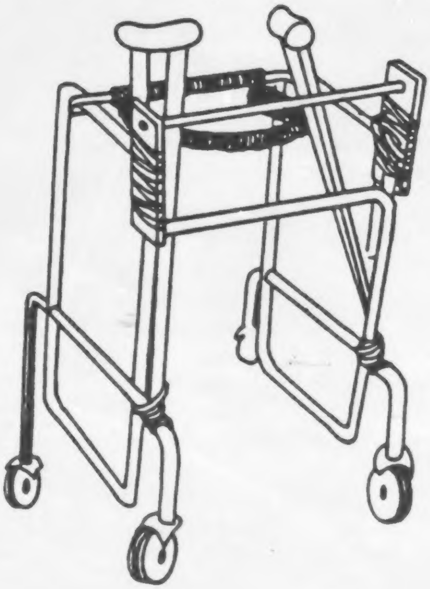
ADAPTED CIRCULAR WALKER

Purpose

- * To provide support necessary to keep trunk upright and aligned in middle.
- * To provide a bar that the child can hold onto while walking.
- * To provide maximum visibility with rest of body.

Construction

1. A high tray or other solid opaque supports were ruled out in an effort to maintain maximum visibility with body and feet.

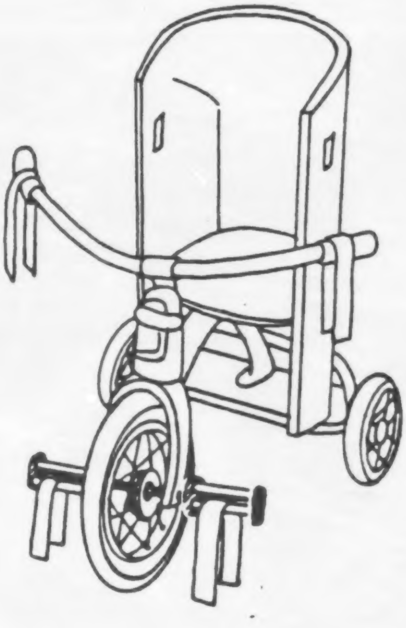


2. Saw off a pair of broken crutches to the desired height (armpit level) and attach to walker at an angle to provide both vertical and lateral trunk support. A combination of heavy cord and electrical duct tape can be used to attach crutches to walker.
3. Attach dowel rod: Cut two rectangles of plywood approximately 2 inches by 6 inces. Drill hole equal to size of dowel to be used in each of the retangular supports. Attach supports to top bar of walker so they sit on one cross piece and lean against upright piece. Attach with duct tape This will raise hand grip to a higher and more forward position. Insert dowel.

Uses or Variations
1. The walker provides maximum support. As soon a possible the support should be faded. The crutch support should be removed. Clear plexiglas panels or wood panels can be fitted over the top bars of the walker to provide elbow support. Later, they too can be removed so the child relies only on the dowel rod.
2. Functional uses: see tricycle.

ADAPTED TRICYCLE

Purpose
- * To provide needed trunk support and foot and hand stability necessary for independent travel.
- * To provide a child with passive experience of reciprocal leg motion as part of a prewalking program.



Construction
1. Buy ½ inch cardboard tubing from an upholsterer (approximately 12 inches in diameter).
2. Cut out a length that is equal to the distance from the base of the tricycle step to the top of the child's shoulders. Cut cylinder in half. Round off the corners by the shoulders.
3. Rest the bottom of the tube on the footplate of the tricycle. Drill two holes through the tube and the metal tricycle seat. Secure with nuts and bolts.
4. Slip velcro straps through the pedals and onto the handle bars.

Uses or Variations
1. The velcro strap can hold affected arm and hand in place on handlebars to provide bilateral experience for the hemiplegic child.
2. Possibly a functional purpose for the child's mobility by having him or her ride the tricycle to and from lunch.

3. Integrate other curricular areas into mobility training when the child becomes more proficient at pedaling. For instance, call his or her name, and if the child comes, reward him or her. Ask him or her to ride to specific parts of the building, in a specific sequence.
4. Integrate riding into prevocational training. Attach a basket to the front of the tricylce have the child deliver the mail each day or deliver messages.

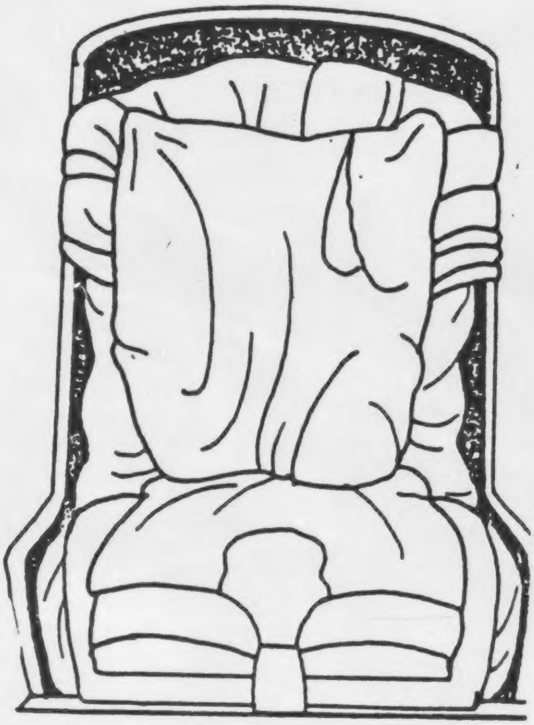
BOBBY MAC INSERTS
(TODDLER AND INFANT SEAT INSERTS)

Purpose

* To provide adaptive sitting posture in commercially available infant and toddler seats.

Construction

1. Trunk piece: Measure the child from his or her bottom to the top of his or her head. Cut cardboard tubing in a semicircle with foam, doubling the thickness at the shoulders and top of thead in order to round the shoulders and keep the head slightly flexed forward.
2. Abductor: (a) Cut a piece of ¼ inch plywood the width of the chair at the child's knees. Glue another piece (approximately 2 inches square) perpendicular to and in the middle of the first piece. Pad and cover with vinyl. Push into place. This kind of abductor also serves to flex the child at the hips since the legs are raised over the insert. (b) Cut a 3 inch length from a 2 inch by 2 inch board. Drill a hole at one end and glue a piece of ½ inch doweling so that at least 1 inch protrudes past the base. Drill a ½ inch hole in the seat of the chair just above the knees. Pad and cover with vinyl.

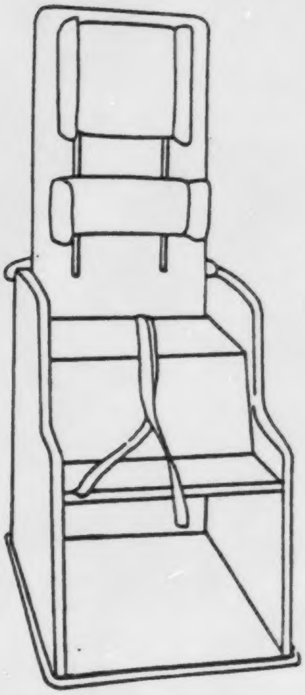


Uses or Variations

If the child sits in more than one chair, the inserts can be removed and placed in each chair to provide proper seating.

RELAXATION CHAIR INSERTS

Purpose
- * To give head and trunk support.
- * To properly position a child with scoliosis.
- * To fit a small child into a larger chair.

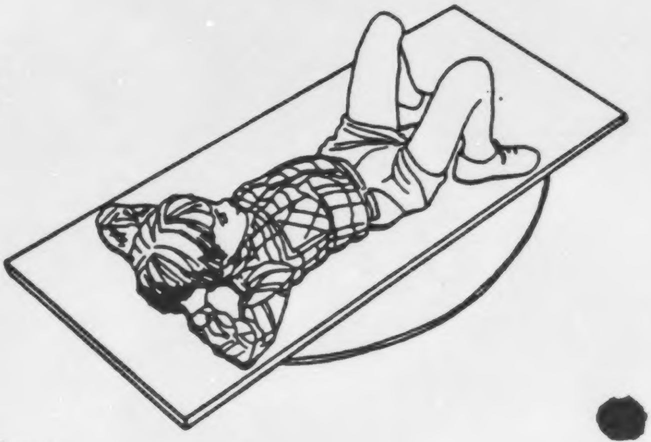


Construction
1. Cut a semicircle of appropriate width and height from heavy cardboard tubing.
2. If the chair does not have them already, cut 2 grooves into the back of the chair.
3. Drill holes into the cardboard pieces.
4. Attach to chair back with long bolts. Adjust up or down as necessary by loosening nuts and sliding along in grooves.
5. Pad the cardboard and cover with vinyl.

Uses and Variations
1. Be sure the head inserts do not unnecessarily obstruct the child's peripheral vision. Trim the sides back as far as possible.
2. If the child is prone to perspire heavily, sew a removable terry cloth cover instead of using vinyl.
3. Chair should tilt back.

VESTIBULAR BOARD

Purpose
- * To provide vestibular stimulation.
- * To help develop protective reflexes.
- * To assist in teaching rolling.



Construction
1. Cut the following pieces out of ½ inch plywood: (a) Circle with 36 inch diameter, cut in half. (These will be the upper surface).
2. Cut a 2 inch by 4 inch board into two 23 inch lengths.
3. Attach rockers to either side of the large rectangle along the 60 inch side. Secure with L braces.
4. Brace the rockers with the 2 inch by 4 inch pieces.
5. Cover the top with carpeting.

Uses or Variations
1. Attach the rockers in the other direction.

2. Make a wider top and use to teach rolling by lying child on side and tilting slightly.
3. The board can be used for sitting, kneeling, or even standing exercises.
4. Cover surface with various textures to encourage handsdown. Change covering from time to time.

LADDER

Purpose

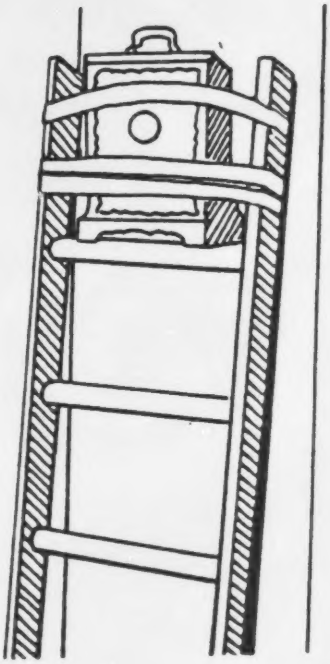
* To develop pull to stand

Construction

1. Two 1 inch by 3 inch boards. Drill holes.
2. 3/4 inch dowels cut in 6 inch lengths.
3. Insert dowels in holes. Glue.
4. As an alternative, a ladder can be purchased and cut to the proper size.

Uses or Variations

1. attach a nonbreakable mirror to the top of ladder as a reward for pulling to knees or standing.
2. Cover each rung with a different texture (foam, fur, carpet.)
3. Attach a music box (as pictured) to top rung.
4. Secure to wall beside toilet, at a 25° angle.



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HANDOUT 32 - INDIVIDUAL RIGHTS

1. Love, honor and freedom from stigma throughout life.
2. Celebration of being special.
3. Life sharing family, home and nurturing support.
4. A community of concern and friendship.
5. Economic security, health and full benefits of modern technology with a continuum of services.
6. Freedom from the threat of injury due to pollution of food, air, water and the earth on which we dwell.
7. The opportunity to grow, learn, choose, work, rest, play, be nourished and to experience well-being.
8. Solitude when needed.
9. Space, comfort and beauty to discover one's self.
10. The power to improve ones personal environment.
11. Justice
12. The dignity of risk, joy and the growth of spirit.
13. A valued social future.

HANDOUT 33 SENSORY ACTIVITIES FOR CHILDREN

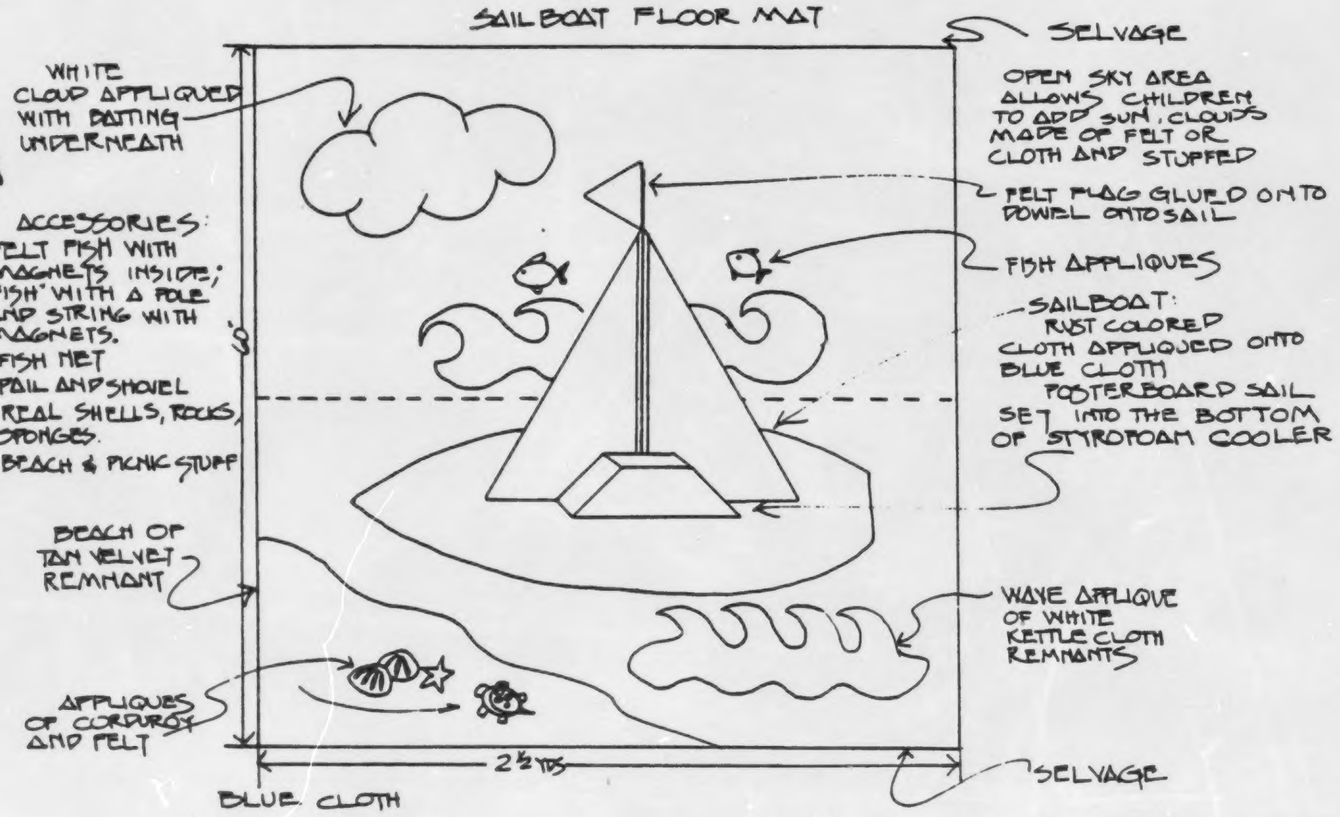
1. ACTIVITY - FLOOR PLAY MATS

SENSES INVOLVED

Tactile, visual

BACKGROUND

A creative floor play mat can transform a floor area into a farm, a jungle, a spaceship . . . the possibilities are as numerous as are different environments! Each mat can be enriched with accessories that add detail to the child's play and create opportunities for children to engage in different kinds of play activities. Action scenes rich with color and texture provide sensory experiences and stimulation for language, role-playing and social interaction. The sailboat floor play mat is described below.


SAILBOAT FLOOR MAT
SELVAGE
WHITE CLOUD APPLIQUED WITH BATTING UNDERNEATH
OPEN SKY AREA ALLOWS CHILDREN TO ADD SUN, CLOUDS MADE OF FELT OR CLOTH AND STUFFED
FELT FLAG GLUED ONTO DOWEL ONTO SAIL
ACCESSORIES:
• FELT FISH WITH MAGNETS INSIDE;
• "FISH" WITH A POLE AND STRING WITH MAGNETS.
• FISH NET
• PAIL AND SHOVEL
• REAL SHELLS, ROCKS, SPONGES.
• BEACH & PICNIC STUFF
FISH APPLIQUES
SAILBOAT: RUST COLORED CLOTH APPLIQUED ONTO BLUE CLOTH
POSTERBOARD SAIL SET INTO THE BOTTOM OF STYROFOAM COOLER
3
BEACH OF TAN VELVET REMNANT
WAVE APPLIQUE OF WHITE KETTLE CLOTH REMNANTS
APPLIQUES OF CORDUROY AND FELT
2½ YDS
SELVAGE
BLUE CLOTH

****

SENSORY ACTIVITIES FOR CHILDREN (continued)

2. ACTIVITY - SPICE PAINTING

This aromatic activity is quite simple to do.

1. Water down any white glue
2. Allow children to finger paint with the glue mixture until it is spread over the paper
3. Shake spices onto the paper and create a work of art
4. When it dries it will feel as interesting as it smells (recommended spices: cinnamon, coffee, onion powder, garlic powder, oregano; for texture: bay leaves, cloves)

SENSES INVOLVED

Visual, tactile, olfactory

* * *

3. ACTIVITY - BAGS AND FILLINGS

Ingredients: Mayonnaise, catsup, mustard or watered down glue; food coloring

1. Spoon a small amount of selected ingredients into a zip lock bag and fasten tightly
2. Allow children to explore the feel of this bag
3. Suggestions for learning:
    - try to blend colors together by pressing
    - make shapes, numbers, letters by pressing on bag with your finger

SENSES INVOLVED

Tactile, visual

* * *

4. ACTIVITY - PEANUT BUTTER PLAY-DOH

Mix: 1 jar of peanut butter (18 oz.)

6 Tbsp. honey

Non-fat dry milk or milk plus flour to the right consistency

Optional: carob powder or cocoa for flavoring

1. Mix playdoh

SENSORY ACTIVITIES FOR CHILDREN (continued)

4. ACTIVITY - PEANUT BUTTER PLAY-DOH (continued)

    2. Shape, roll, or build with the playdoh

    3. Decorate with raisins or nuts and taste

SENSES INVOLVED

Tactile, olfactory, gustatory, visual

****

5. ACTIVITY - SHAVING CREAM ART

    1. Squirt small mounds of shaving cream on a plastic tray or table

    2. Mix food color in if desired

    3. Play with it for fun

    4. Children try make-believe shaving using mirrors, shaving cream and pieces of cardboard

SENSES INVOLVED

Tactile, olfactory, visual

****

6. ACTIVITY - BUBBLE PLAY

    1. Bring in different bubble makers - some blow little bubbles, some blow big bubbles

    2. Add scents or colors to your bubble mixture

    3. If you make your own bubbles, add glycerine for beautiful shine

    4. Make bubble prints by using straws and blowing into a small bowl of bubbles that have food color added. When the bowl is overflowing with bubbles, place a piece of construction paper on the top. You will enjoy the exciting prints.

SENSES INVOLVED

Tactile, olfactory, visual

****